Violence Reduction Programme London

In-Hospital Violence Reduction Services: A Guide to Effective Implementation

March 2022

Royal College of Nursing

Foreword

The purpose of this implementation guide is to support the development and sustainability of in-hospital Violence Reduction (VR) services. This guide is intended for health care professionals working in partnership with local authority and third sector organisations to set up and deliver in hospital VR services. This guide is of particular relevance to medical and nursing professionals, those working in an emergency care or trauma setting, and those working with vulnerable and at-risk young people.

Health and care services can play a unique role in improving wellbeing and tackling inequalities for people impacted by violence.

The NHS London Violence Reduction Programme was set up in 2019 to support clinical teams and co-create approaches that work for communities. We are determined to get beyond receiving people into our hospitals and fixing their injuries.

More than this, to make the NHS an active partner in the holistic solution to a complex challenge, we must change mindsets - to focus on the strengths of our young people, rather than stigmatising them because of the violence they strive to avoid.

The Violence Reduction Programme is necessarily system wide. We bring together communities, clinicians, mental health professionals, voluntary sector organisations and those most acutely affected by serious violence – our young people and their families.

We are developing evidence-based models which support the delivery of high-quality care, wellbeing and recovery for people acutely affected by violence.

This means a person-centred approach which:

- understands the impact on victims of violence and the broader support they need
- champions agency and empowerment with sensitivity to the context and local challenges
- involves communities to find solutions which work
- celebrate and share practices that have been so effective in those unheard spaces.

Understanding the community context means that we can provide health and wellbeing support to young people who previously encountered barriers to the support to which they are entitled – and improve the access, experience, and outcomes for so many. We respect expertise wherever it is found because we recognise that we need our combined knowledge and experience to change all our lives for the better.

We are pleased to share this Violence Reduction In-hospital implementation guide, which provides practical advice to develop effective Violence Reduction (VR) Services within local hospitals. We hope it will help you to develop your hospital violence reduction service to reflect and link into your communities.

Above all, we hope it inspires you to develop hospital services that help to make our communities safer and healthier places to live. We need your help to identify how health and care can encourage our communities to create a more positive future for those affected by serious violence.

Finally, thank you to all the experts who contributed to this guide. Your wisdom and challenge were invaluable.

I look forward to learning with you.
Martin Griffiths

NHS London Violence Reduction Programme

1 Purpose and overview

The purpose of this implementation guide is to support the development and sustainability of in-hospital Violence Reduction (VR) services. This guide is intended for health care professionals working in partnership with local authority and third sector organisations to set up and deliver in hospital VR services.

This guide provides:

- background information on the public health approach to violence reduction,
- an understanding of In Hospital Violence Reduction Programmes, and
- key recommendations to support service implementation.

The recommendations contained within this guide have been developed from an analysis of current in-hospital VR service provision, a review of the evidence base for in-hospital VR services and was informed by experts involved in the provision of in-hospital VR services, including third sector service providers, leading clinicians from Major Trauma Centres (MTCs) ad Emergency Departments (EDs) and young people themselves.

This guide does not intend to prescribe the design and delivery of an in-hospital VR service. First and foremost, in-hospital services must reflect the needs of the local community and tailor their response to suit; this means that services may differ across regions and sites.

2 Violence as a public health challenge

Interpersonal violence, including serious youth violence, is one of the greatest public health challenges our societies face. Violence reduction has been a public health priority for the World Health Organisation (WHO) since it first published guidance on the public health approach to violence reduction in 1996.

The case for change is clear:

- Violence is a major cause of ill health and poor wellbeing.
- Homicide is the third biggest killer of males in England and Wales aged 18 and under, after suicide and road traffic collisions.[1]
- The rate of assaults is increasing – and this increase is disproportionately weighted towards under-18s, with a 65% increase in injuries over 5 years (ONS, 2018)
- Violence in the UK presents significant challenges to the economy, accounting for £2.6bn of NHS spending every year.[2]
- Violence accounts for approximately 2.8% of all ED attendances.[3]
- Gender-based violence such as sexual assault and Child Sexual Exploitation causes significant harm to young people, especially young women. Historically, this kind of violence is both under-reported and responded to poorly. The vast majority of victims are girls, and the vast majority of perpetrators are young men.[4]

Inequality and poverty are understood to be drivers for serious youth violence (Youth Violence Commission, 2020). Poverty is strongly associated with clusters of Adverse Childhood Experiences (ACEs) that can contribute to poor long-term Health Outcomes, including exposure to violence, mental health difficulties, and substance misuse.[5] Many of the key risk factors that make individuals, families or communities vulnerable to violence can be addressed by building resilience and coping strategies from ACEs, in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood and older age.[6]

Taking a public health-based approach to reducing violence involves understanding the risk factors that can lead to violence exposure and developing effective interventions that problem-solve and support holistic wellbeing. This reduces the likelihood for individuals to be exposed to violence. This has wider population health benefits such as improved educational outcomes, employment prospects and long-term health outcomes.[7] Rising violence levels throughout the UK has prompted the government to focus on this issue and support public health approaches taken locally. Tackling violence requires strong collaboration and a partnership working, with health services playing a significant role in reducing the prevalence and impact of violence in local communities.[8] The Home Office released the Serious Violence Duty in May 2021 which required specified authorities (including the NHS) to work together to prevent and reduce serious violence, the causes of violence, and prepare and implement strategies for preventing and reducing serious violence.[9]

3 In Hospital Violence Reduction programmes (IHVR)

What does an in-hospital VR service do?

Hospital Violence Intervention Programmes (HVIPs) were first modelled in U.S. cities including Baltimore, Boston, San Francisco, and Chicago. Typically, the programmes capitalise on 'the teachable moment' – a period of introspection that can be a window in which to offer a fresh perspective and empower a person to regain control of their circumstances.

In the UK, there are many similar services (known as in-hospital violence reduction services (IHVR)) services which are provided predominantly by third sector organisations. In Hospital VR services provide timely and vital support to vulnerable and at-risk young people who enter our hospitals and can provide effective links into appropriate services within local communities. Their teams are comprised of non-clinical professionals with the knowledge (and often the lived experience) of violence, helping them to engage and build rapport with young people. Figure 1 on the next page describes an in-hospital VR service and typical patient pathway.

At the time of writing there are 38 hospital sites in the UK that have a VR service set up; 15 of them are in London (in all four MTCs since 2015, plus a further eleven hospitals), whilst there is a cluster of sites in the Midlands (Wolverhampton, Coventry, Birmingham), notably well-established services in Cardiff and Strathclyde, and an emerging service being set up in Manchester and Liverpool. These services are predominantly provided by third sector organisations in partnership with the NHS.

See Appendix 11 for further information

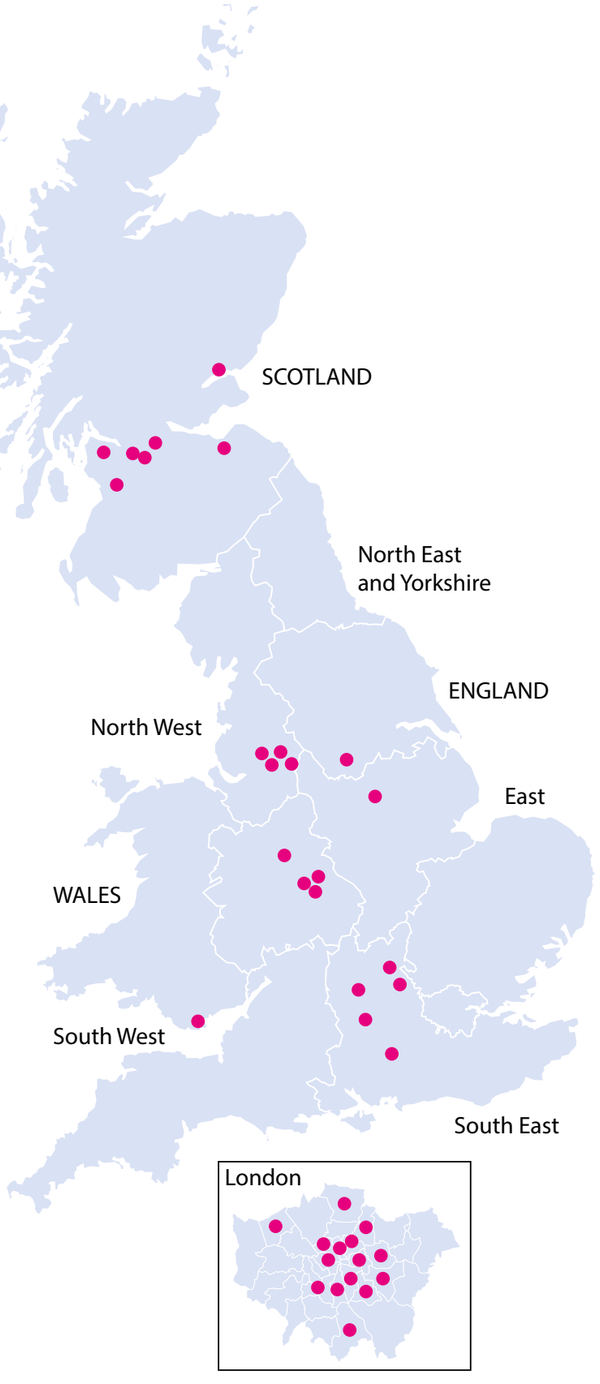
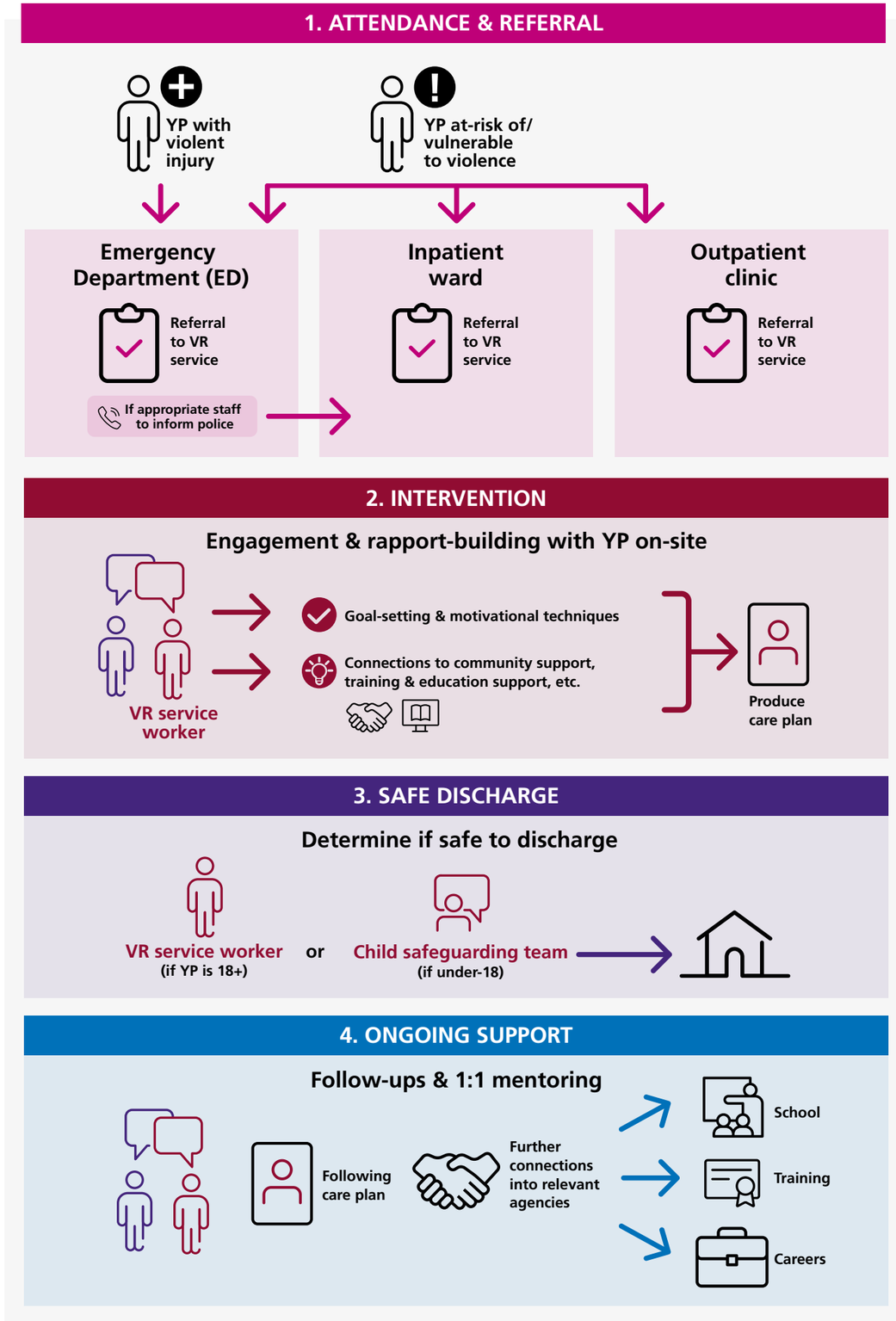


Figure 1: **An in-hospital VR service and typical patient pathway**



The case for change

A study of NHS England data found that 35% of all adolescent (11-19) attendances to an emergency department were for adversity-related injury (self-harm, assault injuries, maltreatment or intoxication)[10], and that 39% of these would attend on multiple occasions during their adolescence.

There is a need to intervene as part of their emergency attendance in order to prevent further harm (and further requirement of health interventions) in future. Many of the young people who have been supported since the inception of the In Hospital VR service would not otherwise have received the help they needed.

An upcoming study from In-hospital services in northeast London (awaiting publication) found that over a five-year period, the re-attendance rate was reduced to 7% in the group that engaged and got support, compared to 15-25% for the rest of the cohort (15% for all NE London, 25% for just the boroughs that the hospital served).

The intensity of support required for young people at risk of harm and exploitation requires a more specialised model of care, beyond the scope of current statutory provision, that is closely networked within the hospital and in the community.[11]

NHS in-hospital VR services fulfil a key role in reducing violent incidents, supporting wellbeing and recovery. They support systems with population health management by improving physical and mental health outcomes, promoting wellbeing and reducing health inequalities across their entire population.[12,13]

To support the case for the development and sustainability of effective in hospital violence reduction services, this guide puts forward a set of key recommendations and resources that can be used to measure outcomes, impact and support service implementation.

Key recommendations for in-hospital VR services

The recommendations can be split into the following thematic areas:

1. **Design and set-up** – including understanding population needs; delivering the service through appropriate provision; funding and costs; oversight of the service; and governance and clinical supervision.

2. **Managing risk and safety** – including responsibilities of different departments and staff to manage risk; guidance on discharging patients safely; and advice on maintaining safety of social media use.

3. **Measuring impact of the service** – measuring impact over the first year; measuring impact in the longer term; key objectives and service KPIs; and information sharing agreements with other agencies.

4. **How the service is networked** – including within a hospital site, between hospitals, and in the community with local partners including local authorities.

5. **Evaluation** – including the use of quality improvement, audit and peer review processes.

1. Design and set-up

Figure 2: **Expectations for setting up and delivering an in-hospital VR service for the first 3 months to 1 year.**

First 3 Months

- Steering Group
- Workforce established
- Honorary Contracts
- Office Space Allocated
- IT access
- Consent process
- Data sharing agreement
- Induction and embedding process
- Face to Face engagement with patients and OOH referral mechanisms established

3 to 6 Months

- Data collection mechanism
- Learning and Development Content
- Teaching Schedule
- Regular Operational Meetings w/ Terms of Reference, Agenda, etc
- Reporting structure in place (n patient presenting, approached, engaging)

6 Months to 1 Year

- Local Policy/SOP for Hospital
- Feedback Loop Established for Referrals Received
- Patient follow up process established - phone, letter, meeting, etc
- Recording of Impact of Interventions (n in work, education, training, etc)

1.1 Understanding population and service needs

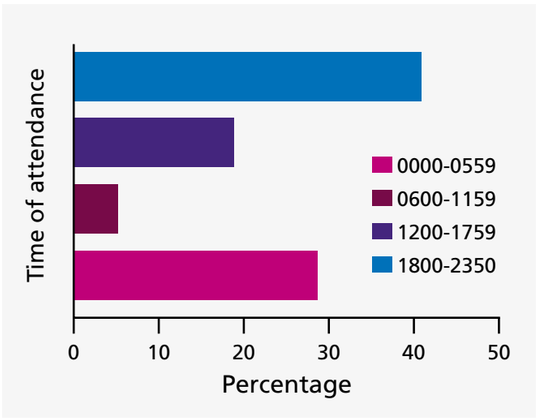
1.1.1 Develop in Hospital VR services for people aged typically between 11-25 years of age.

1.1.2 Use local data to inform service need, drive quality improvement, measure impact and inform evaluations. Data should include:

- attendance rates
- nature of attendance (for example: interpersonal injury, self-harm, intoxication or mental health issues)
- age
- ethnicity
- gender
- days of the week/times of day
- referrals (including those that were declined)
- length of stay
- Interventions
- re-attendance rates
- geographical areas of concern
- clinical settings
- any psychological assessment

The graph below illustrates ED presentation times over a five-year period at an East London hospital, occurring largely in the evening and early hours of the morning, with only around 25% presenting during daytime working hours.

Figure 3: **Attendance times of 2,000 patients aged 11–25 presenting to a London ED following violent injury**



1.1.3 Develop a clear, realistic plan and expectations for delivery of the In Hospital violence reduction service. Outline the deliverables expected for the first 3 months, 3-6 months and 6 months to 1 year. (see figure 2 as a guide)

1.2 Engaging young people in developing and improving services

1.2.1 Work in partnership to co-design, deliver and commission in hospital violence reduction services. Include young people who use the services and those who may benefit from them.

1.2.2 Adopt an individualised approach to the delivery of healthcare services that is tailored to the person's needs and circumstances, taking into account their ability to access services and personal preferences.

1.2.3 Managers of health and social care providers should consider the inclusivity and diversity of their workforce, in particular whether they

- Are representative of the communities they serve.
- Possess staff with cross-cultural communication skills and competencies.
- Hold a positive attitude towards difference.
- Encourage a diversity of experience by promoting healthcare careers to people with lived experience of violence & exploitation, or to those not currently in employment, education or training.

1.2.4 When working with young people who have experienced harm such as violence or exploitation:

- take into account the person may find it difficult to trust professionals in a healthcare setting.
- be respectful of and sensitive to the persons gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability.
- provide trauma-informed care that acknowledges, respects, and integrates a person's cultural values, beliefs, and practices.
- Be aware of Adverse Childhood Experiences (ACEs) and their potential impact.

Figure 4: **Key definitions**

Contextual Safeguarding

is an emerging sociological framework which considers a holistic, system-wide approach to safeguarding young people. The CS framework includes potential harm to a young person beyond the traditional family environment, also known as extra-familial harm. This includes harms such as bullying, child sexual exploitation, child criminal exploitation, and youth violence. Contextual Safeguarding also highlights the contextual dynamics of abuse, moving from a traditional approach which focuses on an individual. It instead incorporates peer groups, schools, social spaces, neighbourhoods, and online experiences.

Trauma-informed practice

(or trauma informed care) is a person-centred approach to healthcare. The principle underpinning TIP is to approach every patient with an appreciation of the hidden impact traumatic experiences can have. Many patients who have experienced severe trauma will not exhibit any symptoms that would qualify as a mental health disorder. Patients however may exhibit behaviours or symptoms that are related to previous traumatic experiences. Sometimes these symptoms may inhibit appropriate socialising, or will lead to someone taking risks or behaving in an impulsive manner, or reacting aggressively in response to a minor setback, such as a delay in delivery of medications.

There is a great deal of emerging neurobiological research that explains how trauma, and excessive stress, can affect the structure of the brain itself, including maintenance of stress hormones. Many patients will have developed maladaptive coping mechanisms to adversity and emotional pain. **Adverse Childhood Experiences** (ACEs) are broadly grouped into three areas – abuse, neglect, and household dysfunction – and have been correlated with poor long term health consequences, and reduced opportunity.

1.2.5 Health and social care professionals working with young people affected by Violence should have knowledge or competency in:

- Understanding the role of healthcare in reducing violence
- Awareness of Adverse Childhood Experiences and their effect on child and adolescent development
- Trauma informed practice
- Contextual safeguarding
- Cultural competence / credibility
- Risk factors in young people for violence and exploitation, and how to spot them

1.2.6 Healthcare professionals should try to avoid jargon wherever possible and be careful not to unhelpfully label or stigmatise a young person and their experiences.

1.3 Delivering the service

1.3.1 Understand the different models that can be used to deliver an in-hospital VR service:

- Sole NHS delivery
- Local authority
- Third sector
- Blended approach

1.3.2 Consider the respective strengths of each when setting up services based on local needs and partnership working. See Appendix 3 for further information.

1.4 Resources

1.4.1 When exploring opportunities for funding:

- be realistic about what the objectives of the service can deliver within the timeframe, use the principles of quality improvement, start small with one site and scale up.
- think about different sources available for funding e.g., health, local authority or third sector partners, violence reduction units, grants, charitable funds and lottery funds.
- Understand it's not uncommon for projects to only be funded for one year at a time.
- Build in costs to evaluate the project to help ensure sustainability of services.
- When funding is secured, put the project out via tender, and ensure smaller, local organisations also have access to this tender process.

1.4.2 Consider a minimum of three WTE (one team leader and two case/support workers) for an averaged sized ED. Additional consideration should be given to clinical staff with dedicated responsibilities, such as a specialist nurse role or clinical lead (consultant level).

Figure 5: **Suggested composition of a Steering Group**

NHS Host Organisation

- Project Lead (Nursing or Clinical Lead)
- Named Doctor/Nurse for Safeguarding
- Senior Paediatrician
- Service Manager (Emergency and Acute Care)
- Representative from Divisional or Hospital Executive

Service Provider

- Regional programme lead or project manager
- Team Leader

Local Authority

- Senior member of Community Safety Partnership
- Children's Services representative
- Child Criminal Exploitation (CCE) Programme Manager

1.5 Oversight of the service

1.5.1 The host organisation should set up a Steering Group within the hospital to help support implementation, ensure continued buy-in (including at an executive level) and help troubleshoot any challenges (including those related to Human Resources, IT infrastructure and information governance)

See Appendix 5 for further detail on how to address these challenges.

1.5.2 NHS staff involved in the Steering Group should include:

- A senior clinical lead (ideally consultant level) who can lead on the pathway design, implementation of the service and ensure buy-in from clinicians.
- A senior nurse who can dedicate time to support VR service staff on a day-to-day basis (i.e., oversee governance issues, arrange teaching, clinical supervision);
- A service manager who can support the logistical aspect of contracts, data sharing arrangements, desk space, IT access, room bookings etc. and can ensure processes occur in a timely manner.

1.6 Governance and clinical supervision

1.6.1 Establish a governance structure as part of the Standard operating procedure (SOP) or policy agreed for the provision of a violence reduction service. This may mirror the composition of the steering group, but it is important to establish the clear lines of reporting and escalation.

1.6.2 In Hospital Violence Reduction Workers should have access to a named clinical supervisor. This could be a hospital clinician or a senior person within the Trust.

2. Managing risk and safety

In Hospital Violence Reduction Workers should be employed by the organisation providing the service but should operate within the clinical environment under the basis of an honorary contract. This ensures the team can be compliant with hospital expectations of health and safety, information governance, etc.

2.1.1 Violence reduction workers under an honorary contract should be expected to be able to approach patients, relatives and other visitors without first obtaining permission by clinical staff.

2.1.2 A risk assessment of the service will need to be completed, including an up-to-date COVID risk assessment of the violence reduction workers that will be based in the hospital. Hospital trusts should consider the risk of violence towards patients and staff as part of their hospital risk register, as well as actions to mitigate any potential harm to patients, staff or visitors.

2.1.3 If an incident occurs it may need to be managed separately by both the host site and the organisation providing the worker. Ie in the case of a patient complaint, the response may have to be generated by the trust, but actions may need to be managed separately by the service provider.

There are key requirements that should be considered to ensure the safety of young people attending hospitals with violence-related injury. Hospitals are a public access building, so staff should appreciate the risk of repeat or reciprocal violence within the hospital setting.

1.
The hospital's risk register should feature the potential risk of victims of violence sustaining further violent injury whilst an inpatient.

2.
Clinical staff should be encouraged to develop a philosophy of professional curiosity to identify risks factors that predispose a child or young person to harm or exploitation.

3.
Senior clinical staff, especially those working within the ED, should have working knowledge of trauma-informed care and contextual safeguarding frameworks.

There are key requirements that should be considered to ensure the safety of young people attending hospitals with violence-related injury. See appendix 7 on good practice points on how to manage risk and safety of patients and staff.

3. Measuring impact of the service

A key priority of In-hospital violence reduction services is to reduce harm experienced by young people and improve their long-term health and wellbeing by providing and effective and responsive violence reduction service.

3.1 Using data

3.1.1 Consider the use of the following metrics to help measure the impact of an In-Hospital Violence Reduction service:

- Re-attendance rates
- Number of young people who receive an intervention or are offered support compared to the total number of young people attending hospital due to extra-familial harm.
- How many young people complete goals set within their personalised support plan.
- Comparison of a psychosocial or health and wellbeing questionnaire at both the start and on completion of a support plan.

3.2 Measuring the service's impact in the first year

The aim of the first year is to get the service underway, building the violence reduction infrastructure from the hospital and out into the community, and creating opportunities to engage with more young people. By recording data from day one services can also reflect on this period, identifying success within the delivery of service, and future opportunities to grow the service further. Agreed outcomes in the first year are usually generous and flexible, appreciating the challenges of rolling out a novel intervention in a new clinical environment.

3.2.1 Consider using the following outcomes to measure the impact of the service in the first year:

- Improving connections with young people,
- Improving referral rates; and
- Demonstrating engagement are featured within the impact assessment.

Note: it is not reasonable to expect a clear recording of significant outcomes and a drop in injury/hospital attendances as processes are still being embedded. In some cases it can take 6 months for a service to become fully operational, especially if funding become available in a brief window of time.

3.3 Measuring the service's impact over the longer term

3.3.1 To aid evaluation and trends, it is important that the VR service keeps a record of:

- Each intervention that takes place;
- Every conversation or phone call;
- Referrals made and followed up;
- How many young people engage with the service, and
- What the support designed for them looks like.

This will help with any future longitudinal evaluations as well as providing nuanced details of the value this kind of service brings to a hospital.

3.3.2 From year two onwards, violence reduction service providers should be able to more clearly define the impact of their service, in particular who is being supported by the service, and in what way they benefit. Key points would include

- Who is being supported (demographics, especially age, gender, ethnicity)
- Who has not been supported i.e. declined, not contacted (demographics)
- How young people were identified and engaged with,
- what support was provided, and
- what impact this support has over time (health, education, social outcomes)

3.4 Key Performance Indicators (KPIs)

3.4.1 In hospital violence reduction services should develop a clear and achievable set of key performance indicators (KPIs) to help monitor and drive service performance and improvement. See appendix 8 for a proposed set of KPIs[1].

3.5 Information sharing agreements across the different agencies

3.5.1 Hospitals, local authorities and third sector partners should establish local data sharing agreements, in line with GDPR and the Data Protection Act 2018. Consider how high-level data can be shared to accurately record young people's interaction with health services across specialities and geographical areas.

1 These KPIs have been developed from a review of existing KPIs used within London and expert consensus.

4. How the service is networked within the hospital and with the local health and care system

4.1.1 Set up a violence reduction service network within the hospital that uses data to share best practice and learning with relevant services (for example trauma networks, local authority community safety partnerships, Primary care, relevant educational provision (school nurses, CAMHS etc) and violence reduction units)

4.1.2 Build effective relationships and establish clear communications with key partners such as the local authority, community safety partnerships, children's services, community interest groups, local volunteering services, and local employers or training and education providers to ensure a consistent joined up approach to a person's care, working together to prevent and reduce serious violence.

5.Evaluation

5.1.1 Undertake a service evaluation as part of essential and regular improvement activity. At the planning stage of evaluation consider the following:

- The underlying model for improvement,
- What information is required for the evaluation, what routine information that can be used (see recommendation 1) and if any additional information is required?
- The methods and skills for analysing the data that is collected.
- The resources required to carry out the evaluation.

5.1.2 In order to appreciate the impact the service has had on the young person, risk assessments should be clearly documented and follow ups should be recorded wherever possible. There should be a repeat risk assessment conducted at close of the support period, or at 6 months. This data should be anonymous, but accessible to the host hospital as well as the funders, and service providers.

5.1.3 Collate case studies of good practice, learning and outcome data and ensure this data is regularly share with Violence Reduction Team to help provide feedback and support continuous improvement. Case studies provided to clinical staff working in the hospital will also maintain engagement, and help to illustrate the importance and relevancy of the service.

5.1.4 Carry out clinical audits, peer review and use quality improvement methodologies, to help monitor and drive continuous improvement in patient care. See appendix 10 for suggested peer review standards[2].

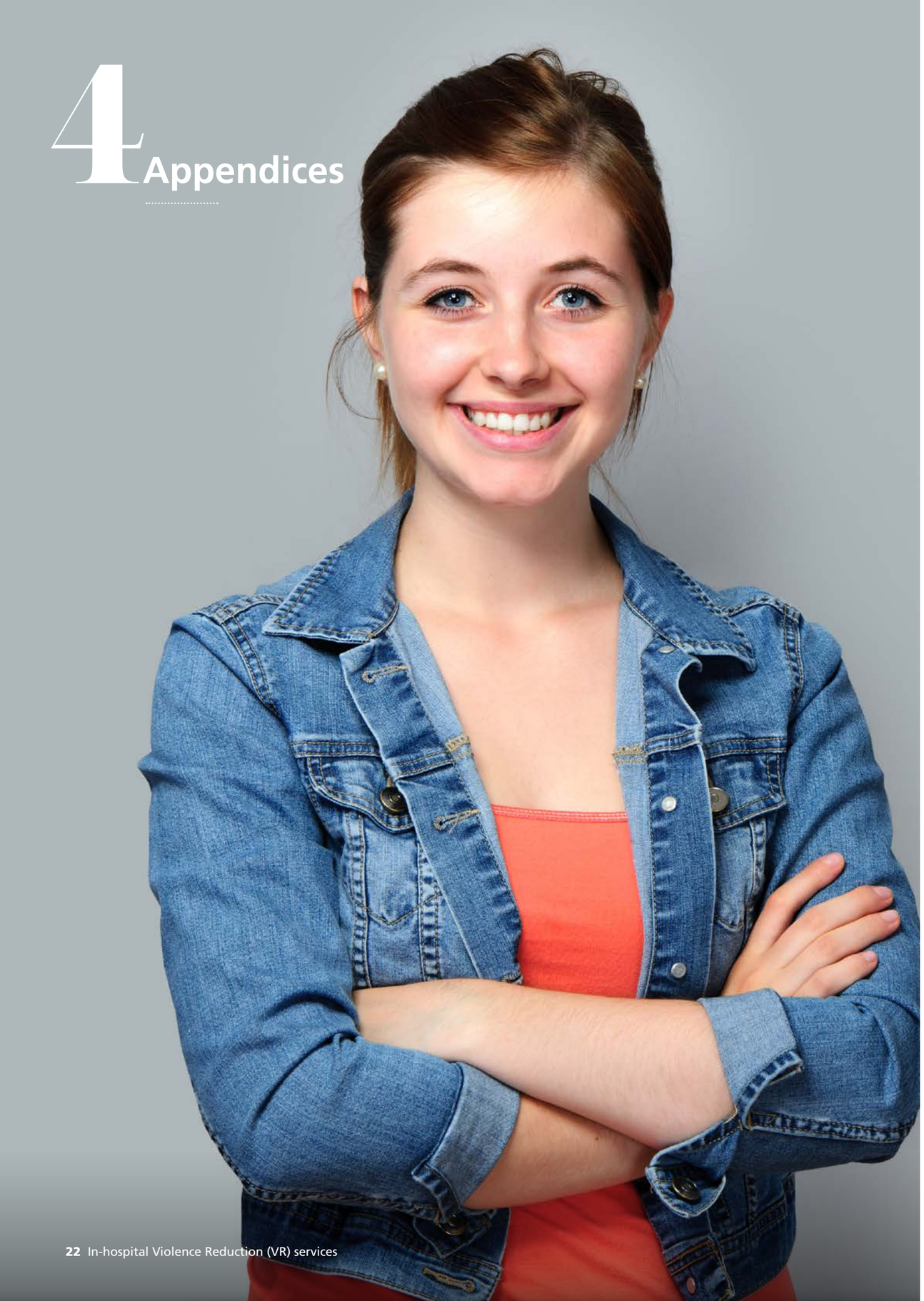
5.1.5 Data of all referrals, assessment and interventions should be collected and stored in a secure but locatable digital location. A regular and periodic clinical audit should also be established via the hospital's digital record.

Figure 6: **Top 10 outcomes prioritised as part of a US delphi exercise by practitioners involved in delivering hospital-based violence intervention programs[13]**

1. **Decreased** violence victimization
2. **Reduced** hospital recidivism due to violent injury
3. **Reduced** participant mortality
4. **Reduced** exposure to violence
5. **Decreased** posttraumatic stress symptoms
6. **Reduced** risk for retaliation
7. **Better** coping strategies
8. **Change** in belief regarding need to retaliate
9. **Decreased** aggression
10. **Improved** emotional regulation and control

2. These peer review measures will be piloted within North East London and Essex Trauma Network in 2021.

4 Appendices



Appendix 1: Different examples of how in-hospital VR services can be delivered

Sole NHS delivery example

Some hospitals have dedicated clinical staff delivering interventions related to violence reduction, this role has also focused on improving data sharing and collaborative working with other partners to support the patient both in and out of the hospital.

The benefits of this approach include the ability to fit within an existing governance structure, staff already having experience of patient advocacy and an understanding of the clinical environment, and the reality of sustained and challenging emotional experiences.

Research demonstrates that interventions with the most impact require a young person to be supported over many days or weeks, sometimes months[14]. This level of intensity is difficult to sustain for clinical staff with other responsibilities. The ability to deliver care for young people at risk of harm and exploitation also requires a specialised skillset, as well as additional desirable qualities such as cultural competency and lived experience. Roles such as this do not routinely exist as part of a formal NHS career pathway.

Example:

John Radcliffe Hospital in Oxford has an NHS-employed Community Safety Practitioner who works in the hospital's ED with a full-time violence reduction remit. They are a member of the Thames Valley Violence Reduction Unit, which is also currently coordinating the Navigator Programme to based in the Horton General Hospital ED[15].

Local authority example

Another option is for hospital sites to collaborate directly with a local authority to provide a service. By working directly with a community safety partnership, the VR service staff have a large amount of resources and intelligence at their disposal, which can aid coordination of longer-term support for young people.

Organisation and alignment of agreed pathways across two complex, large partners can make aspects of the work more convoluted, perhaps requiring sign off and agreement across multiple tiers of management. Statutory thresholds may also force decisions on which young people receive support, which at times can appear counter-intuitive.

Example:

The Community Safety Partnership at Tower Hamlets created the Engage programme to support young people attending ED at the Royal London Hospital who do not require admission to hospital. The team have excellent outreach services in the community, and have the benefit of added intelligence of tensions within the local community. A year-two report will be published shortly.

2 These peer review measures will be piloted within North East London and Essex Trauma Network in 2021.

Third sector provider example

Third sector organisations are currently the most common workforce used to deliver this model of care. Practitioners from third sector organisations are experts by lived experience, and can bring a fresh perspective into the hospital environment. By being independent of both health professionals and law enforcement they can act as a bridge between statutory services and the hospital, allowing for new networks of communication. The case workers sometimes share similar backgrounds and experiences to the young people they support. One of the greatest tools the teams have to hand is the ability to be culturally credible in a way healthcare professionals sometimes struggle to do, despite best intentions.

Example:

In the West Midlands, in-hospital VR services provided by Redthread are currently embedded within the Queen Elizabeth Hospital and Heartlands Hospital in Birmingham. In New Cross Hospital (Wolverhampton) and Walsgrave Hospital (Coventry), the West Midlands VRU commissions St Giles Trust to provide in-hospital services.

Third sector provision can take longer to set up in the early stages as they do not always fit neatly into existing NHS HR and governance frameworks. Most of these programmes are established with the help of external funding, which must be an early consideration, especially in terms of sustainability. Use of professionals with lived experience is an excellent opportunity to demonstrate a transformative process, especially in consideration that some staff members may hold previous criminal convictions. Collaboration between institutional and charity sector HR departments can work to understand and mitigate any perceived risk, of which to date there has been no demonstrable negative outcome.

Blended delivery model example

There have been circumstances where local authorities have opted to fund an in-hospital service through a third sector organisation, allowing for close partnership working between the local group/authority, the NHS Trust and the third sector provider. An advantage of this approach is in the co-ordination and planning of the service, meaning more doors are open for the VR service to take advantage of. It also means the interests of all partners can be understood and aligned from the outset, including the potential to match fund.

Example:

The VR service delivered at Whipps Cross Hospital by St Giles has been directly funded by Waltham Forest Violence Reduction Partnership. From the outset the design and set up of the programme has occurred in close partnership between the local authority, St Giles, and Barts Health NHS Trust.

Currently, third sector provision or the emerging mixed delivery model are the most prevalent and well-evidenced options for service provision. However to support these delivery models funding will need to be much more sustainable and provided via several large statutory funders working in partnership.

Appendix 2: Summary of current evidence base for in-hospital VR services

Current Evidence Base

The following section covers brief summaries of the existing knowledge base around in-hospital VR services.

Hospital-based programme methodology

- Baltimore (Cooper, D, 2006) – a randomised control trial of 100 patients attending Shock Trauma Centre, Baltimore with violent injuries identified a reduction in hospital re-admission rates from 36% to 5% in a control group compared to patients who received support from a case worker or social worker. Additionally, 82% went into full time employment after their hospital admission, in comparison to 20% of the control arm.[16]
- Glasgow Navigators (Magill, S, 2019) – a retrospective study of a Glasgow ED showed that following an intervention from the Navigator team (provided by Strathclyde VRU) attendance rates dropped by 24%, compared to a control group whose attendance rate increased by 15%.[17]
- MOPAC evaluation (Parker, R, 2017) – an evaluation of the London major trauma centre provision of in-hospital VR was carried out between 2015 and 2017. It examined the methodological approach, as well as data on referral and engagement rates. Data shows self-reported reduction in crime and participation in violence in young people who engaged with the service, however the impact analysis was unable to robustly determine whether there was any reduction in exposure to violence or exploitation.[18]
- St Thomas' report (Ilan-Clarke, Y, 2016) – A retrospective study conducted by the University of Middlesex determined that the re-attendance rate of young people who engaged with Oasis youth workers dropped from 35% to 19%, and that around 60% of young people who participated in the service achieved their intervention goals by the end of the intervention. Some recommendations from the paper included more cross-comparison of models and outcomes, and improvement of data sharing pathways.[19]

Models of working/assessment

- Violent Reinjury Risk Assessment Instrument for hospital-based violence intervention – qualitative interviews with VR practitioners in the US led to the development of an algorithmic structured professional judgement model of assessment. The researchers are now using multicentre prospective data to validate the tool.[20]
- HAVI – America has established the Health Alliance for Violence Prevention, meaning that any hospital treating at least 100 violence-related injuries is expected to set up a Hospital based Violence Intervention Programme (HVIP). Their objectives and funding priorities are designed in alignment with the CDC and Department of Justice, which recognise these services decrease health and societal costs. The costs of interventions are now reimbursed through Medicare and Medicaid[21].

Population studies

- BMJ Open - Retrospective cohort study of geographical and temporal patterns - Incident timings and locations were obtained from ambulance service records and triangulated with prospectively collected demographic and injury characteristics recorded in hospital trauma registry. The authors used geospatial mapping of individual incidents to investigate the relationships between demographic characteristics and incident timing and location. Stab injuries occur in characteristic temporal and geographical patterns according to age group.[22]
- Adolescent adversity and injury re-attendance – A longitudinal study of over 140,000 hospital admissions over 15 years noted that 40% of adolescent males and 50% of adolescent females who attended with adversity-related injury (self harm, assault, intoxication) would re-attend the ED on more than one occasion. The re-attendance rate was even higher for those noted to have multiple adversities.[23]

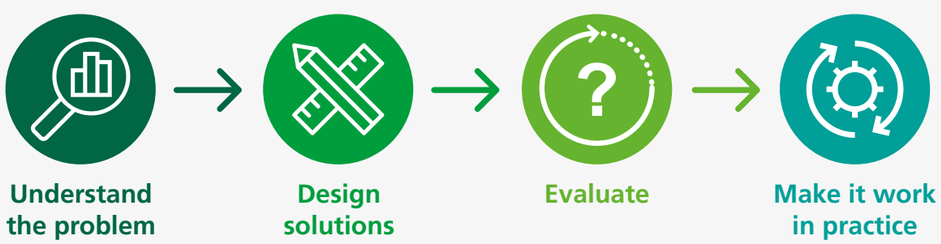
Findings from the Behavioural Insights Team

It has been recognised by the Behavioural Insights Team – a social purpose organisation who undertook a Strategic Needs Assessment to inform the approach to violence prevention in London – that evidence on what works to prevent violence is thin.

The Behavioural Insights Team identified 10 key recommendations to help the Violence Reduction Unit (VRU) in London to optimise efforts to stabilise and reduce violence in the immediate and longer term.

- Improve our ability to measure, understand, monitor and anticipate violence.
  - Improved use of Cardiff model, data sharing on domestic abuse, etc
- Commission research on the neighbourhood and situational drivers of violence in London.
- Use advanced analytical models to identify predictors of risk and intervention opportunities
- Design solutions drawing on evidence of what works.
  - There is a lack of Randomised Control Trials
  - The majority of contemporary evidence is coming from the USA.
- Work with communities to adapt evidence for the local context.
  - Lack of translation of US to UK studies – UK has better social support than the US, so the impact from interventions is smaller.
- Ensure interventions reach those who need them.
- Take a pragmatic approach to evaluation in the immediate term.
  - 'The vast majority of violence reduction initiatives in London are not being rigorously evaluated'
- Generate a pipeline of interventions that can be more rigorously evaluated in the medium to long-term.
- Provide the resources, incentives and connections to drive iterative research and experimentation.
  - Data sharing agreements
  - Provide partners with resources to research, analyse and evaluate
  - Find funding for initiatives
- Make multi-agency working as easy as possible.

Figure 6: **Taken from Violence in London: what we know and how to respond (The Behavioural Insights Team, 2020)**



Appendix 3:
Summary of types of partnership and network arrangements

Violence reduction as a model of care delivery is reliant on strong networks. This includes interactions within a **single hospital site**; interactions **between local hospitals in an Integrated Care System** (ICS) and **interactions between the hospital, local authorities and other organisations**.

a) Interactions within the hospital site

Within a hospital there are multiple professional networks that exist within distinctive services, departments and individuals – all of which would benefit from interacting and understanding the in-hospital VR service. There can be a misconception that the service is an ED or 'front door' facing initiative and not for other wards and departments too.

Violence reduction should become part of a hospital's vocabulary. When mapping out the organisational structure that an in-hospital VR service sits within, consider typical ward environments that patients who have experienced violence are admitted to. Also consider areas in the hospital that young people at risk of violence or exploitation might visit.

Case study:

A young person with long-term medical conditions was found to be in possession of a knife. Due to the visibility and knowledge of the hospital's VR service, the team co-ordinating the young person's medical care were able to get in touch with the service and provide a supportive intervention as part of his regular outpatient visits.

b) Interactions with other local hospitals

Hospitals cannot be regarded as silos within the context of reducing violence. Young people may be injured and taken to a hospital away from their local area, especially if they have sustained injuries that necessitate a major trauma response. A young person's home address, school, college, place of work, or social hubs may exist in a separate borough to the hospital, meaning that a borough-specific response may not always be adequately inclusive.

Information sharing between hospitals inside the same Integrated Care System (ICS) is not yet achievable. While some information sharing is standardised, for example referrals to children's services, it is not routine to access information about a young person's medical history, or perceived risks of harm as identified by health services.

A young person might regularly attend a hospital with assault injuries but on attendance to a an MTC there may be no record of previously identified risk. This is confounded by the practice of many hospitals generating generic patient details to facilitate rapid diagnostics and treatment as part of a trauma team response.

There are precedents for establishing improved information sharing networks, for example between MTCs, and by incorporating pre-hospital arrangements with ambulance services and helicopter emergency medical services. Furthermore, ICSs offer a framework in which to prepare and publish agreed network protocols, formal information sharing agreements, even procurement and or match-funding intentions, and this opportunity should be utilised by violence reduction partnerships.

Case study:

Two young people attended a Major Trauma Centre with stab injuries, who lived in a different borough to the hospital they'd attended. The violence reduction caseworkers had a good relationship with a outreach worker from the same borough as the young people. In conversation it became apparent they had supported both young people previously. The outreach worker was invited into the hospital and a support plan was developed in-person and collaboratively to ensure the young people could stay safe once they were fit to leave hospital.

c) Partnerships between the hospital, local authorities and other organisations

In-hospital VR services need to consider their interactions with partnerships across the borough, both statutory and third party. Some of the young people attending hospital may already be known to children's services, youth offending teams or other youth outreach work. However, research suggests that only a small portion of young people affiliated with gang activity are known to services of any kind.[24]

There is a need for hospitals to communicate concerns about patients who attend hospital with violent injuries. Only by better information sharing can we build more effective care pathways across different agencies. To do this the hospital and partners in local authorities and the third sector need to improve data sharing mechanisms to understand the demand and need within the local system.

Third sector and local authorities can provide intelligence and contexts of violence and risk within neighbourhoods, background information on young people and families (in particular the extent of risk) and means to refer a child or young person into a much wider network of interventions and resources than are available in a hospital. Once again, ensuring good governance through the establishment of a Steering Group will aid such collaboration and information sharing. Such a group could perhaps be facilitated through the trauma network, or via the relevant VRU.

Case study:

Dr Adrian Boyle (Addenbrookes Hospital) and Prof Jonathan Shepherd (Cardiff University) joined a research team, in partnership with not-for-profit research institute RAND Europe, to undertake research into the uses of A&E data by police in England and Wales. They developed up-to-date guidance (published 2014) for police practitioners on available A&E data and its potential uses, as well as on how to establish and maintain data-sharing partnerships with NHS partners.[25,26]

An in-hospital VR service can act as a bridge between different networks, effectively allowing a process of sharing intelligence and working practices and opening up respective partnerships and networks to one other. Strong partnership working is a valuable component of effective violence reduction and is a way of ensuring some consistency in approach and shared vision in service delivery, even across a growing network of partners providing what is understood to be a complex intervention.

Case study:

At the Royal London Hospital where a new mentoring scheme was enabled due to existing connections with external partners. Students from a nearby Pupil Referral Unit were invited to work on the trauma ward as peer volunteers one day a week, and in return received a high quality of training and one-to-one support. Volunteers at the end of the project were offered healthcare apprenticeship places within the hospital.

Appendix 4:
Violence Reduction Induction Checklist

Violence Reduction Service Induction Checklist

Staff Name .....

Clinical Supervisor .....

Start Date .....

	TASK	DATE COMPLETED
1	Honorary contract arranged	
2	Occupational Health check completed	
3	COVID risk assessment carried out	
4	Mandatory training completed	
5	IT network access acquired	
6	NHS smartcard acquired	
7	nhs.net email activated	
8	Workspace identified in hospital	
9	Invitation to psychosocial meetings	
10	Local induction- Emergency Department (ED)	
11	Local induction – wards	
12	Local induction – clinics	
13	Identify link nurse AND doctor per division/department - ensure regular teaching slots	
14	Out of hours referral process established	
15	Database of eligible/referred/seen patients (saved centrally on Trust computer)	
16	Establish link with local CSP	
17	Establish link with local children's services	
18	Establish link with local domestic abuse services	

Appendix 5:
Three priority areas for a Steering Group to address

Human Resources (HR)	The youth workers/case workers who form the in-hospital VR service will be employed in the hospital via honorary contract process. It's vital that the key manager for honorary contracts in the HR department is identified early, and that a manager or director of the division that will be responsible for the VR service (typically emergency care or trauma) is ready to oversee applications and process and approve honorary contract requests as they come through. All staff working within the VR service will need to provide their CV and other personal details, will be subject to a DBS check, and will need to undergo occupational health screening and attend mandatory training for the Trust. Some staff members working as part of the VR service may have spent convictions or offences on their record. In the context of a VR programme, lived experience of criminal justice is usually an asset more than a risk. Most can demonstrate as living proof to young people that change is possible.
IT infrastructure	The VR service service will need to have NHS email activated and will need to have access to hospital digital records system. If available, staff should also have virtual access to the network created at the same time.
Information Governance (IG)	All emails correspondence must be sent from nhs.net emails. Email correspondence must only be sent to secure and approved email addresses if the content of the email pertains to a young person the service is supporting. All other communication must be in line with local information governance policy. The VR service should have all access to medical notes, and the ability to document assessments and interventions in the medical notes, where appropriate. Often this documentation supports the wider work going on to support the young person, including discussions with housing services, children's services, police, etc. The service should be entitled to approach a young person and/or their guardian in order to obtain consent to engage. It should not be necessary for a clinician to first obtain consent prior to the VR service seeing the patient. Typically, the VR service should be entitled to approach and interact with the patient on the grounds of their honorary contract status. Wording of the honorary contracts should be checked to ensure this is the case.

Appendix 6:
Health and safety advice in the context of COVID-19 for in-hospital VR services working in Acute Trusts

Background

The NHS recognised that workers within our partner organisations delivering in-hospital VR services should have key worker status conferred; to support this, there was agreement in 2020 of a framework of risk assessment, infection control, and social distancing. The overriding imperative was that the return of these services did not compromise patient or staff health.

In 2020 guidance was drafted to outline how NHS healthcare providers and third sector partners take the necessary steps to ensure the safety of their workforce. This was co-developed by NHS London's Clinical Director for Violence Reduction, London's Clinical Lead for In-Hospital VR models, and representatives from third sector partners including Redthread, St. Giles and Oasis Youth Support

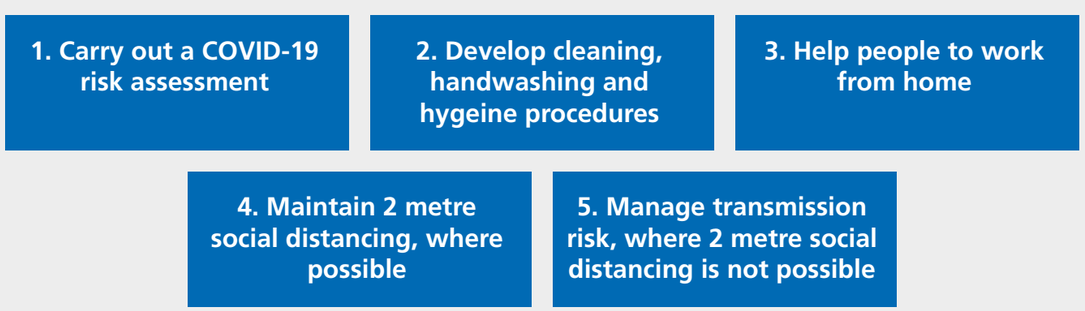
COVID-19 health and safety principles

These principles were expanded in the context of in-hospital VR services, with guidance covering five key points for services to adhere to:

1. **Risk assess the workplace, the workforce and individuals (and their circumstances)**
2. **Adherence to local policies on infection control and hand hygiene**
3. **Working from home is the safest option and should still be the default means of working (including engaging with patients virtually and remote working**
4. **When not working from home, minimise contact with colleagues, patients and visitors**
5. **Staff must stick to 'green' areas as much as possible. Working in 'amber/red' areas should be based on a risk assessment, and the employee's ability to protect themselves**

3 https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/5-steps-to-working-safely

Figure 7: The Government's five key principles for working safely during COVID-19[3]:



Appendix 7:
Good practice points for managing risk and safety

There are key requirements that should be considered to ensure the safety of young people attending hospitals with violence-related injury. Hospitals are a public access building, so staff should appreciate the risk of repeat or reciprocal violence within the hospital setting.

1. The hospital's risk register should feature the potential risk of victims of violence sustaining further violent injury whilst an inpatient.
2. Clinical staff should be encouraged to develop a philosophy of professional curiosity to identify risks factors that predispose a child or young person to harm or exploitation.
3. Senior clinical staff, especially those working within the ED, should have working knowledge of trauma-informed care and contextual safeguarding frameworks.

See the responsibilities for various staff and settings summarised below. For guidance on the safe operation of a service during COVID or a similar pandemic environment, see Appendix 4.

a) Responsibilities of hospitals to manage risk and safeguard patients.

Emergency Department (ED)

- An In-Hospital Violence Reduction service should be available to young people presenting in the Emergency Department.
- Presentations of concern to emergency department staff may include:
  - *Injuries as a result of interpersonal violence – for example knife wounds, or facial injuries. Consider especially the time of day, and the geographical location the injury took place.*
  - *Injuries with an inaccurate or vague history - for example an injury from punching a wall, penetrating injury from falling onto glass, playfighting injuries.*
  - *Inappropriate time to present – for example a sports-related injury that presents at 2am in January.*
  - *Children and young people presenting with acute intoxication or adverse effects of drug use, who are under-age, or otherwise showing signs of potential exploitation.*
  - *Children and young people presenting with signs of potential exploitation – for example swallowing drug wraps or being found in possession of drugs/weapons.*
- If a patient attends with an injury after being attacked with a bladed weapon, staff should consider whether it is appropriate to call police via 999 to report an incident of a stabbing. If a patient attends with a gunshot injury, police must be notified immediately via 999 in order to protect the patient, staff and other visitors to the department.

- If multiple patients attend ED from the same incident, security and site team must be informed to safeguard both patients and staff. In the case of an escalating outside incident, advice should be sought from the police, and presence requested in the hospital.
- All victims of violence should be offered the opportunity to speak to a violence intervention worker in-hours, and to be referred to a violence intervention worker out-of-hours.
- The ED must include safety concerns about their patients as part of routine clinical handover.
- All patients attending the emergency department with interpersonal injury who do not require admission to hospital should be seen in-person by violence reduction caseworkers in-hours and referred to violence reduction caseworkers out-of-hours (with patient consent in the case of OOH referral).

Site management

- If a patient is admitted with violence-related injuries, it is important to make the site management team aware to support in ensuring patient safety during an admission.
- There may be circumstances in which patients must outlie on non-typical wards to avoid admitting potential rivals into the same clinical space. Multiple patients attending due to violence who live in the same or neighbouring boroughs should be assumed to be a risk to one another unless proven otherwise.

Inpatient Ward

- Wards should have a designated violence reduction lead for their area, who can coordinate training and ensure the referral process and collaborative working is optimised.
- Ward staff must advocate for their patients in times of vulnerability and challenge visitors who should not be there, involving security if necessary. Unwanted visitors should be documented as part of shift handover.
- Ward staff must also ensure to hand over any perceived risk towards patients when they are being transferred or stepped down to another ward environment.
- Patients under the age of 18 who are victims of interpersonal injuries should have a discussion with the Children's Safeguarding team prior to discharged from hospital until an agreement that it is safe for them to go home. If patients of any age have children or siblings under 18 at home, then a children's safeguarding referral should be made.

Outpatient and other Clinics

- Patients at risk of harm in the clinic setting are entitled to the same support structure available to patients in the ED or the ward environment and clinical staff have a responsibility to respond to signs that a patient may be at risk of harm.
- In a clinic setting the signs may be more subtle, but it should also be seen as an additional opportunity to identify and support young people at risk of violence or exploitation.

Security

- Security should be informed if a patient is concerned for their personal safety in hospital, or if clinical staff have concerns for a patient's safety while they are in hospital.
- Security should be informed if more than one patient attends the hospital with violent injuries that may be related; if the patients are known to pose a potential or perceived threat to one another; or if the patient's visitors may pose a threat to either patients or each other.
- Security have a responsibility to ensure visitors are not allowed into clinical areas without the express permission of the staff co-ordinating that area.

Clerical and Electronic Records

- Rate of injury, rate of referrals, demographics of victim profiles and rates of re-attendance are examples of data that can be routinely audited through electronic records queries.
- Hospitals use the Emergency Care Data Set (ECDS) which is the national data set for urgent and emergency care. This data set is being updated to include essential data points to be compatible with the Information Sharing to Tackle Violence (ISTV) information standard ISB1594[27] set by NHS Digital. Hospitals are currently collecting this mandatory data separately, but in future will collect this data as part of the same process.
- A member of staff should be identified who can collect and analyse this data, which should be easily auditable through digital medical records.
- Prior to the patient's discharge from a ward, admin and clerical staff must ensure the patient has the correct NHS number allocated. This is essential for safeguarding, sharing relevant information with primary care services, and to monitor potential risk in future.

b) Managing risk when discharging patients

- VR service staff have a unique perspective on risk – their insight and advice in conjunction with those of law enforcement and the trust safeguarding teams are central to safe discharge.
- All patients aged 11-25 should be discussed with and/or referred to the violence reduction caseworkers prior to discharge.
- If a patient is deemed unsafe for discharge they should have a documented discharge plan to establish required steps before the patient is safe to be discharged home or repatriated to another facility.
- A patient over the age of 18 who has capacity to make decisions for themselves can leave hospital against the advice of clinical staff. VR service staff should be informed to ensure follow-up can happen in community.
- If a patient under the age of 18 wants to leave against the advice of clinical staff, they should remain in the department until a responsible adult can collect them.
- Prior to discharge, victims of violence should be checked on the system for any previous presentations with similar or related injuries. Patients with previous attendances of this nature should be seen as high risk for further injury in future and referred to the violence reduction service as a priority.
- GPs should be notified as a routine part of discharge information that the patient was a victim of violence, as this may help to facilitate necessary support in the community after discharge.

c) Risks of social media

- Clinical staff should take a pragmatic approach to social media, ensuring that the patients understand the potential risk of engaging with social media whilst in a hospital setting.

For further info, see advice and guidance for professionals working with young people at

www.net-aware.org.uk,

www.youngminds.org.uk

and **www.catch-22.org.uk.**

Appendix 8:
Key Performance Indicators (KPIs) for in-hospital VR services

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
1. Establishment of an effective programme	**Programme Commenced**	Service is fully operational within the hospital. • All posts recruited into • Induction process completed for all staff • Team is integrated into the hospital network and have all necessary accesses and allowances • Baseline data is recorded reliably and objectively, and is easy to access	This is a 3-6 month embedding process that is the key component of a successful VR service. The service must be fully operational within this time frame.	Fully recruited within 3 months of commencement. Fully operational service within 6 months. Baseline measurements established and reviewed ready for target-setting at the end of year one.	Implementation checklist – yes/no This should be standardised across all service providers. Every service will need honorary contracts, email access, access to medical records, information sharing agreements.	Yes/No Continued funding and NHS endorsement beyond year one is dependent on fulfilment of all year 1 criteria.
	VR infrastructure built from the hospital and into the community	• Information sharing protocol is established with hospital and statutory services. • VR service is a recognised component of local borough approach to violence reduction and/or community safety. • VR service is included within footprint of adult and children's safeguarding	This is an extension of the embedding process to ensure the VR service has good intelligence and resources at hand, especially beneficial for teams that may not employ their workforce from the local community.	Data sharing agreement submitted to ICS. Team included within community safety meetings. Team are included within children's services and safeguarding meetings.	Creation and signoff of formal processes and agreements.	Yes/No Continued funding and NHS endorsement beyond year one is dependent on fulfilment of all year 1 criteria.
	Opportunities created to progressively engage with more young people	• Capture objective data of exact numbers of eligible young people attending ED. • Establish a baseline of how many young people seen and engaged compared to total numbers.	Important to understand how many potential/eligible young people pass through the hospital.	Exact numbers of YP known for the year. Data personnel identified at the hospital. Reporting process set up to measure successful contacts and engagements.	Quarterly reporting.	Yes/No Establishment of quarterly report, and mechanism for reliably and independently recording the total numbers eligible, and seen.
2. Identification and Support	**Improved identification of victims of violence (11-25)**	• % of ED admissions identified as eligible for VR service / referred to VR service by clinical staff. • % previously attending ED with adversity-related injury • % previously attending ED with violence-based injury	The goal is to year-on-year improve identification and understanding of cohort. Important not only to know which young people have been identified, but also any that have been missed. It is also important to understand how many CYP are using ED services due to adverse circumstances.	Baseline collected in year one. Goal to achieve 100% identified eligible CYP	Quarterly reporting Cross-checked with independent clinical data collection – ie through spot audit of 1 month.	Aim to achieve 100% identification.
		• Include n of CYP being flagged as a safeguarding risk as part of service reports and evaluation • Include n of younger siblings or children of CYP flagged as a safeguarding risk as part of service reports and evaluation	Important to understand relationship between violence, exploitation and volume of referrals/workload to safeguarding. Data collected through psychosocial referrals/reports from children's safeguarding	Aspirational goal of all CYP at risk flagged to safeguarding.	Included as part of quarterly reporting. Numbers referred to safeguarding available through audit.	Yes/No

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
2. Identification and Support	Increased engagement of young people with support	• % of eligible CYP successfully contacted by VR service (conversation in person or via telephone not including voicemail) • % of CYP who engage and consent to support. • % of CYP who did not require or did not accept offer of support	This is an indicator of how successfully the VR service is finding, contacting and engaging with CYP. Important to measure metrics in terms of total numbers as well as percentages, as numbers can fluctuate year on year. Voicemail should not count as a successful contact.	Numbers likely to vary year to year. Expectation that proportion who agree to support increases each year. Important metric for purposes of KPI and evaluation is the % of CYP who consent to support that were successfully contacted.	Included as part of quarterly reporting Data collected in year 1 will form baseline rate.	Outstanding – increase in engagement by more than 5% Good – increase in engagement by 0-5% Requires improvement – decrease in engagement by 0-5% Inadequate – decrease in engagement by more than 5%
		• % of eligible CYP taking up opportunities for ETE • % of eligible CYP supported with advice and guidance • % of young people referred onto specialist support services that the VR service does not cover (ie specialised ETE, psychological support, drug and alcohol) • % of CYP successfully discharged from VR service – ie support plan completed • % of CYP who disconnected from service prior to completion of support plan	Research suggests that support with ETE is large component of what makes service work, therefore a key evaluation metric is to ensure CYP are receiving support plans, and advice and guidance on achieving goals.	Percentage of total eligible more important than overall numbers, as numbers will fluctuate. Aim for 5-10% improvement each year.	Included as part of quarterly reporting Data collected in year 1 will form baseline rate.	Outstanding – increase in engagement by more than 5% Good – increase in engagement by 0-5% Requires improvement – decrease in engagement by 0-5% Inadequate – decrease in engagement by more than 5%

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
3. Risk and Harm Reduction	Reduced short term risk of harm	• % of CYP who receive a documented formal risk assessment of low/med/high • % of CYP who have risk factors documented – including previous offending behaviour and criminal charges – within the assessment • % of CYP who have a formal support plan created in regards to risk assessment • % of CYP with reduction in immediate risk from initial assessment • % of young people reporting improvement to feelings of safety • % of CYP reporting improvement to stress and wellbeing (including anxiety, mood, anger, substance use)	The documentation of a formal risk assessment is a key part of understanding future risk of injury/offending behaviour, by completing as many as possible we can better understand how risk should be managed in future. We would expect the majority of CYP who successfully engage with VR services to see a reduction in risk. Complete as part of a standardised evidence-based assessment to be agreed across all VR services.	Percentage of total eligible more important than overall numbers, as numbers will fluctuate. Aim for 5-10% improvement each year. Percentage of total eligible more important than overall numbers, as numbers will fluctuate. Aim for 5-10% improvement each year.	Included as part of quarterly reporting Data collected in year 1 will form baseline rate. Included as part of quarterly reporting Data collected in year 1 will form baseline rate.	Outstanding – increase in engagement by more than 5% Good – increase in engagement by 0-5% Requires improvement – decrease in engagement by 0-5% Inadequate – decrease in engagement by more than 5% Outstanding – increase in engagement by more than 5% Good – increase in engagement by 0-5% Requires improvement – decrease in engagement by 0-5% Inadequate – decrease in engagement by more than 5%

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
3. Risk and Harm Reduction	**Reduced long term risk of harm**	• % of CYP demonstrating reduction in overall risk from initial assessment to completion of support/6 months • % of CYP demonstrating increase or no change from initial assessment to completion of support/6 months • % of CYP who have reduction in documented risk factors after 6 months • % of CYP who report improvement of emotional wellbeing and mental health after 6 months.	6 month follow ups have previously been difficult to capture, but provide an important metric as to whether CYP are staying safe and well. Use the same standardised risk assessment for initial, follow up and 6 month follow up.	Percentage of total eligible more important than overall numbers, as numbers will fluctuate. Aim for 5-10% improvement each year.	Included as part of quarterly reporting Data collected in year 1 will form baseline rate.	Outstanding – increase in engagement by more than 5% Good – increase in engagement by 0-5% Requires improvement – decrease in engagement by 0-5% Inadequate – decrease in engagement by more than 5%

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
4. Vulnerability and repeat victimisation	**Reduction in exposure to violence**	• Reduction in number of attendances, and re-attendances to ED each year • % of CYP who self-report improvement to violence exposure or victimisation • % of CYP who do not re-attend hospital with violence-related injury within 12 months of attendance (rolling) • % of CYP who do not re-attend hospital with violence-related injury long term (ie from point of engagement up to age 25)	This metric is not based on the individual CYP, but on aggregate data. Standardised self-assessment tool across all services. Re-injury rate is not the only measurable metric, but is a core aspect of the reason the VR service was initiated. As a next step it is important to understand how many CYP remain injury free over a longer period of time.	Aim for 5-10% imrprovement on self-report each year. Aim for rate below national average for re-attendance (approx. 35%)	Included as part of quarterly reporting	For comparison to national average <10% - outstanding 10-30% - good 30-40% - requires improvement >40% - inadequate.

Outcome Theme	Outcome	Aims and Expectations	Rationale	Target	Measurement	Success criteria
5. Knowledge, Training and Awareness	**Awareness of the VR service and the support mechanisms available**	• VR service delivers training as part of level 3 children's safeguarding • % of ED nurses received training from VR service in the last year • % of ED doctors received training from VR service in the last 3 months • % of clinical staff across site who are familiar with the VR service	This ensures the VR service is incorporated into core service provision ED staff will deliver majority of referrals, so require the most frequent training. Medical staff rotate every 3 months. This can be identified through a sample/spot check	Delivery at every L3 children's safeguarding session Aim for increase in trained nurses year on year. Aim for 100% awareness amongst ED medical staff. Aim for increase in awareness each year	As part of audit through trauma network peer review.	100% - outstanding 60-100% - good 40-60% - requires improvement Below 40% - inadequate
	Improved knowledge and understanding of the issue of violence in community around hospital	• Relevant clinical staff report improvements to their understanding of needs of CYP in local community • Relevant clinical staff report improvements to their understanding of violence, CCE, CSE, and issues like trauma informed care.	This ensures the hospital, and clinical staff that work there, are also demonstrating growth and development in this field.	Publication of narrative review to accompany end of year report. Questions asked as part of peer review.	Annual narrative report including rates of teaching delivered and subjects covered, feedback and self-assessment. Evaluation also included as part of trauma peer review process	Pass/fail

Appendix 9: Setting SMART goals for Quality Improvement (QI)

Specific

- What do I want to accomplish?
- Why do I want to accomplish it?
- What are the requirements
- What are the challenges

Measurable

- How will I measure progress?
- How will I know when the goal is accomplished

Achievable

- How can the goal be accomplished
- What are the logical steps I should take?

Relevant

- Is this a worthwhile goal?
- Is this the right time?
- Do I have the necessary resources to accomplish this goal?

Time-Bound

- How long will it take to accomplish this goal?
- When is the completion due?
- When am I going to work on this?

Using the example of missed referrals, a SMART goal based around this challenge may look something like this:

MISSED REFERRALS TO VR SERVICE IN EMERGENCY DEPARTMENT (ED)	
Specific	Improve referral rate to VR service in the ED. Referrals are the mechanism by which young people are assessed and supported, especially when attending hospital out of hours.
Measurable	Measure rate of referrals or missed referrals in three months and compare to the current referral rate. Aim for a 50% reduction in missed referrals over three months.
Achievable	Provide training for all clinical staff Ensure referral process is clear, easy to follow and well-advertised. Provide monthly updates to keep track of progress. Identify if there are patterns as to why referrals are missed (ie times of day, minor injuries, paediatrics v adults).
Relevant	The more patients that can access this service, the more opportunities there are to provide meaningful support and prevent future harm. This programme has been embedded for a year so is a good time to implement a change. There are sufficient staff in the VR service, and there is sufficient clinical support at the hospital.
Time-Bound	Improvement project to run for three months, with a review at the end of each month, accompanied by an update email to the hospital staff, and to the programme managers. First complete teaching presentations and visual displays, then pro-actively engage with clinical staff, then monitor progress and update as required.

Appendix 10: Peer Review Standards

The table below outlines some key standards that services may want to refer to for purposes of peer review. The example standards included are based on recommendations made in previous sections of this guide, and are currently being piloted across three sites in London as part of a trauma network peer review.

	In-hospital Violence Reduction Peer Review – September 2021	
Standard	**Yes/No N/A**	**Evidence (documentation or file/photo)**
1. VR service has sufficient staff to meet the demands of all young people requiring an intervention in hospital.		
2. VR service has sufficient staff and resources within their network to ensure medium to long term support for young people once they leave hospital.		
3. VR service has mechanism for making out of hours referrals, and has the resources to ensure each of these referrals are followed up.		
4. The VR service are invited to the psychosocial meetings for the Trust and attend these meetings regularly.		
5. VR service staff have an allocated working space and access to IT and comms infrastructure.		
6. Staff across the hospital Trust have access to regular specialist training provided by the VR service or associated clinical experts.		
7. Trust clinical staff are aware of the presence of VR services in the hospital, and know how to refer into the service when asked.		
8. The VR service records assessments and support plans clearly and for every patient who agrees to an engagement. These support plans include a RAG rating of risk for the young person, and goals which are achievable and can be reviewed at the close of engagement, or at 6 months, whichever is sooner.		

Standard	In-hospital Violence Reduction Peer Review – September 2021	
	Yes/No N/A	Evidence (documentation or file/photo)
9. The VR service can provide data on a. number of total CYP attending with violent injuries b. number of CYP highlighted at risk of violence or exploitation c. number of young people referred to the service d. the number of CYP contacted successfully e. the number of CYP agreeing to support f. the number of young people who later returned to hospital with another injury. The VR service keeps a historical record of all young people, and compares their records with data queries run by the hospital.		
10. The VR service stores their case notes and data in secure folders held within the Trust network, and keep physical documents in locked cabinets.		
11. The service takes part in Quality Improvement initiatives, and can demonstrate a quality improvement project that they have worked on in the last year.		
12. The VR service collaborates with other clinicians / organisations to develop evidence that supports continued provision of an in-hospital VR service.		
13. The hospital has a member of staff who collects and shares data as part of the ISTV initiative.		
14. The hospital has a policy or SOP in place to protect patients that may be at risk of violence during their stay.		
15. The hospital features the VR service as part of their governance structure.		
16. The hospital has an established working relationship with the local community safety partnership.		
17. Hospital clinical staff learn about contextual safeguarding, CSE and CCE as part of level 3 children's safeguarding.		

Appendix 11: List of services

England

- University Hospital Coventry & Warwickshire (St Giles)
- New Cross Hospital, Wolverhampton (St Giles)
- Queen's Medical Centre, Nottingham (RedThread)
- Manchester Royal Infirmary (Oasis)
- Royal Bolton Hospital (Oasis)
- Salford Royal Hospital (Oasis)
- Royal Manchester Children's Hospital (Oasis)
- Queen Elizabeth Hospital, Birmingham (RedThread)
- Heartlands Hospital, Birmingham (RedThread)
- Northern General Hospital, Sheffield (MAV Navigator programme)
- The Horton, Banbury (Connection Support)
- Milton Keynes Hospital (Milton Keynes YMCA)
- Wexham Park Hospital (Aik Saath)
- The Royal Berkshire Hospital (Starting Point)
- The Stoke Mandeville Hospital (7 Road Light)

London

- Kings College Hospital (RedThread)
- The Royal London Hospital (St Giles)
- St George's Hospital (RedThread)
- St Mary's Hospital (RedThread)
- Homerton University Hospital (RedThread)
- North Middlesex University hospital (Oasis)
- Croydon University Hospital (RedThread)
- University Hospital Lewisham (RedThread)
- Greenwich District Hospital (RedThread)
- Newham Hospital (St Giles)
- Whipps Cross Hospital (St Giles)
- University College of London Hospital (RedThread)
- Northwick Park Hospital (St Giles)
- St Thomas' Hospital (Oasis)
- Whittington Hospital (St Giles)

Wales

- Cardiff and Vale – University Hospital of Wales (St Giles)

Scotland

- Glasgow Royal Infirmary (MAV Navigator programme)
- Royal Infirmary of Edinburgh (MAV Navigator programme)
- Queen Elizabeth University Hospital, Glasgow (MAV Navigator programme)
- University Hospital Crosshouse, Kilmarnock (MAV Navigator programme)
- Royal Alexandra Hospital, Paisley (MAV Navigator programme)
- University Hospital Wishaw (MAV Navigator programme)
- Ninewells Hospital, Dundee (MAV Navigator programme)

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