Uned **Atal** Trais
Violence **Prevention** Unit

A Service Evaluation of the Delivery and Implementation of a Hospital-Based Violence Prevention Team within the University Hospital of Wales

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Contents

Acronyms

A&E	Accident and Emergency Department
ACE	Adverse Childhood Experience
COVID-19	Coronavirus
ED/ EU	Emergency Department / Emergency Unit
HCA/ HCSW	Health Care Assistant/ Health Care Support Worker
IDVA	Independent Domestic Violence Advisor
ISVA	Independent Sexual Violence Advisor
MARFs	Multi-agency Referral Forms
MTC	Major Trauma Centre
NHS	National Health Service
NPS	National Probation Service
PCC	Police and Crime Commissioner's Office
PHW	Public Health Wales
PPN	Public Protection Notifications
SOC	Serious Organised Crime
UHB	University Health Board
UHW	University Hospital of Wales
VPT	Violence Prevention Team
VPU	Violence Prevention Unit
VRU	Violence Reduction Unit

Executive Summary

Levels of violence, including knife crime, gun crime and homicides, are on the rise in England and Wales, particularly among younger populations (1). A high proportion of violent incidents result in injury, therefore, professionals in healthcare settings (e.g. Emergency Departments [EDs]), are particularly well-placed to identify and respond to patients involved in violence. However, research suggests that support for patients with violence-related injuries can be limited to their health care needs, thus, fail to address the causes of the injury and the wider needs of the patients (2).

Hospital-based violence prevention interventions are being establish across the UK. These services seek to identify and intervene with children and young people involved in violence at what is considered a 'teachable moment', at a time they are most vulnerable and may be more inclined to engage with services to address their vulnerabilities. In Wales, the Violence Prevention Unit (VPU) has funded the development and implementation of a Violence Prevention Team (VPT), to operate within the ED in the University Hospital of Wales (UHW), Cardiff. The team comprises of a nurse and violence prevention advocate who are situated within the ED, and a caseworker based within the community (attached to the Action for Children Side Step programme). The service was established to engage with patients who attend the ED with violence-related injuries, with the aim to improve police reporting, and provide advice, support and guidance to encourage engagement with services and promote movement away from violence.

A process and outcomes evaluation of the VPT was carried out, to explore the development and implementation of the service within the ED and the nature and level of support provided to patients with violence-related injury. A mixed methodology was used, which included an online survey with hospital staff (e.g. doctors and nurses in the ED; n=54) and 1:1 interviews with service providers and clinical staff working alongside the VPT (n=12). Service level data was also obtained from the VPT on patients with violence-related injuries attending the ED over the period of a year (April 20- March 21).

Findings

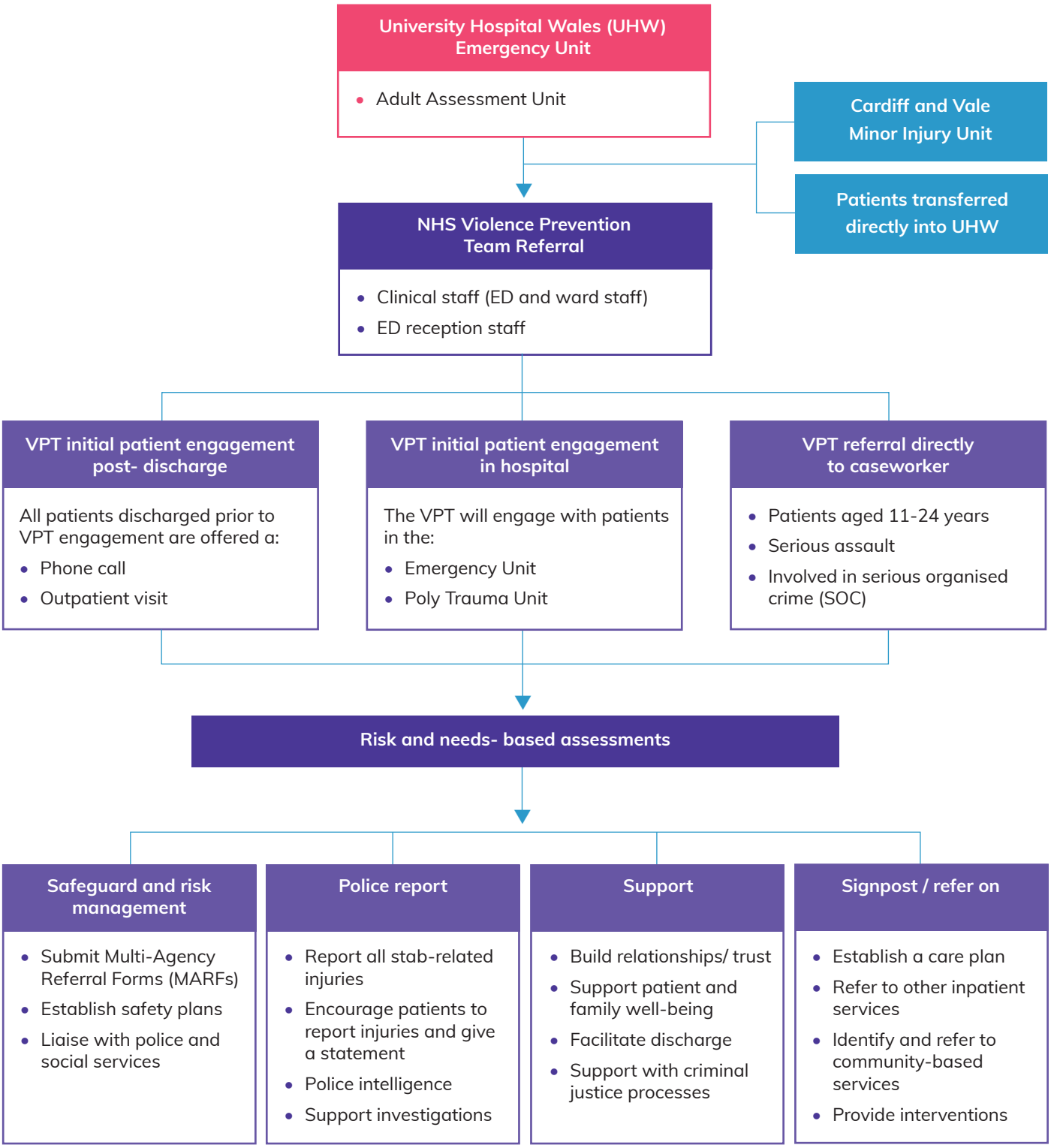
The role of the Violence Prevention Team

The hospital-based VPT offer support to all patients presenting to the ED with non-domestic violence-related injuries, while working alongside the Independent Domestic Violence Advisors (IDVAs) to support patients with domestic violence- related injuries. In contrast, the community-based caseworker accepts referrals specifically for individuals aged 11-25 years who have presented to the ED with injuries that have resulted from a serious assault, and who are involved in serious organised crime and drug activity, or shows signs of exploitation. The stricter referral criteria for the caseworker allows them to provide longer-term, intensive support to higher risk children and young people, while the hospital-based VPT can offer early intervention and support to all patients with violence-related injures to prevent escalating harm.

The support provided to victims of violence-related injury

The support the VPT provide patients can vary significantly, determined by the patient's level of vulnerability and unmet needs, and their willingness to engage with the service. The team will engage with each patient at the earliest opportunity, attempt to establish a relationship, conduct risk- and needs-based assessment, and identify services to refer the patient on to (see figure 1 for the VPT processes). This approach offers flexibility to staff, and has improved safeguarding and risk management within the hospital, with fewer patients with violence-related issues leaving the ED undetected and unsupported.

Figure 1: *An overview of the support provided to patients with violence-related injury*



By utilising external agencies, the VPT can provide patients with access to support which addresses a wide range of needs, many of which are risk factors for further involvement in violence. This includes services to address mental health and emotional well-being, housing problems, drug and alcohol abuse, criminality, and interpersonal relationships. Furthermore, through the Side-Step programme, the community caseworker offers children and young people on their caseload access to a range of interventions for emotional regulation, self-esteem, relationships and behaviour.

Delivery and implementation of the VPT

The VPT was established by the head of safeguarding for Cardiff and Vale University Health Board, in collaboration with the VPU. Participants reported the service to be well-established within the ED and wider departments within the Health Board, and considered the service to be beneficial for patients with violence-related injuries.

In particular, the participants highly valued the individual roles chosen to deliver the service, with each professional providing experiences which are unique, complimentary, and valuable to effective service delivery. During the interviews, the participants stated that the nurse provides clinical knowledge and awareness of the internal processes within the hospital, which has supported the integration of the service into the ED and facilitated interactions with patients, doctors and wider medical teams. The participants further explained that the advocate has an understanding of safeguarding and criminal justice processes, and agencies external to the hospital, while the caseworker has extensive experience working with vulnerable children and promoting positive changes in their lives.

Participants reflected that the composition of the team has facilitated patient and staff engagement. While attendance to the ED were lower during COVID-19, the VPT continued to operate and deliver face-to-face support within the hospital, and have been successful with patient engagement. Over the period of a year, 75% (n=358) of all patients attending the ED with violence-related injury engaged/ interacted with the service (April 20-March 21), while 16 patients successfully engaged with the caseworker for intensive support (40% of individuals referred; June 20-March 21), including vulnerable children and young people who have disengaged from all other services.

Furthermore, positioning the VPT within the ED, as part of the safeguarding team, has enabled them to provide considerable support to staff within the hospital. It has permitted them to deliver formal training on violence, data entry and patient coding, safeguarding practice and the policies for reporting injuries to statutory agencies (e.g. police). The team also provide less formal advice and guidance to staff, and at their request will consult with them on patients.

Benefits of the VPT

In the survey, 100% of respondents reported the VPT to be beneficial in supporting patients with violence-related injury, 85% of which rated them highly beneficial. The VPT has increased access to support for patients, many of whom present with high levels of vulnerability. For example, in the period of a year (April 20- March 21) the VPT referred 44% of all patients with violence-related injury onto another service (n=208 of 447 patients), and submitted Multi-agency Referral Forms (MARFs) for a quarter of patients. As a result, the service has reduced the level of hidden harm through better identification of the patients with violence-related injuries, and improvements to data entry, which has allowed for a better understanding of the true nature and level of violence-related injuries attending the ED to be captured.

The findings highlighted significant benefits of the service for staff. Survey respondents reported that the VPT have improved their knowledge and awareness of violence and how to respond to patients. As a result, the staff were highly confident responding to patients presenting with violence-related injury, including: identifying injuries which have resulted from violence; their understanding of reporting responsibilities, procedures and processes; and, making a referral to safeguarding services. However, less than half the sample felt highly confident engaging with patient's intimate partners, discerning the cause of injuries, attaining an accurate account of how injuries occurred, providing advice and support to patients, and accurately coding and recording injuries.

Challenges and areas for further development

Participants reported the need to increase the capacity of the service and to ensure the team are available in the ED to respond during the peak hours for violence-related injuries (e.g. weekends). However, on-going assessment of demand is needed as COVID-19 restrictions ease. Furthermore, there is a need to increase the capacity of the community-based caseworker to enable them to increase the number of children and young people offered longer-term intensive support, and to enable them to maintain capacity to respond to emergency incidents (e.g. mass stabbings).

The VPT reported challenges working with partner agencies, and highlighted the need to further develop the support provided from other agencies, as well as collaborative working. In particular, the team reported a need to increase access to mental health and well-being services for patients, particularly for patients who have experienced a significant trauma.

Furthermore, the caseworker expressed interest in enhancing how they work with criminal justice agencies, particularly the prison service, to ensure children and young people have continuity of support and receive rehabilitation if they are incarcerated.

Service sustainability and wider roll-out

Participants felt the service has the potential to be rolled out to other hospitals in Wales, however, felt it needed to continue to be co-delivered with the police through the VPU to maintain its current strategic priorities. In order for the service to be sustained and rolled out wider, longer-term funding is needed, which strategic leads in health felt could be achieved through joint funding from the police and health services.

Conclusion

The service has been successfully embedded into the hospital, and has established an effective model for responding to patients. The service has begun to demonstrate positive outcomes, including improved safeguarding, greater access to support for patients, and improvements to staff knowledge, awareness and confidence responding to patients with violence-related injuries. However, further work is needed to understand the impact of the service on patients, and the cost-benefit of the service to obtain longer-term funding.

Recommendations

Based on the evaluation findings presented, it is recommended that:

- The VPT continue to engage criminal justice agencies, including police, prison, probation and the youth justice service, to identify further opportunities to enhance collaboration in supporting individuals involved in violence.
- The NHS identify and secure a longer-term commitment of funding for the VPT, and explore opportunities to continue to develop the service within the Health Board.
- The VPT to continue to operate as a collaboration between police and health, to ensure the service maintains a focus on violence prevention and vulnerability.
- The VPT consider their operating times, by monitoring and assessing the volume of patients attending the ED, and patient engagement with the service on evenings and weekends.
- The service explore opportunities to increase the capacity of the community-based caseworker to enable them to offer the intensive, longer-term support to a higher number of children and young people at high risk, who are presenting to the ED.
- The service and strategic leads further identify or establish mental health and well-being support for individuals who have experienced trauma, and who are involved in serious organised crime, drug related activity, and have been exploited.
- The VPT strategic leads commission further evaluation of the VPT, including an impact and economic evaluation, exploring the impact of the service on violence victimisation and perpetration (e.g. re-injury, re-attendance and arrest rates).
- The VPT explore opportunities to deliver further training to staff within the hospital, to enhance their knowledge and awareness of violence, and confidence to respond to patients.
- The VPU and VPT work together to fully understand the challenges with the existing standardised data collection system, and consider opportunities to further improve data collection.

Section

1

Introduction

1.0. Introduction

Globally, violence is a pervasive public health concern, which places a heavy burden on the health of individuals, communities, and societies across the life course. Exposure to violence can have a lifelong impact on individuals, and increase their vulnerability to emotional, behavioural and physical health problems (3). As a result, interpersonal violence places a significant strain on public services, including health, criminal justice and social care services, costing an estimated $1,240 billion globally each year (4).

In particular, interpersonal violence among young people (youth violence) is an area of growing concern, and is ranked as the third leading cause of death among 10-29 year olds in Europe (5). Youth violence, which is commonly associated with the drug market, gang culture, organised crime groups and exploitation, can have a wide range of consequences for children and young people. This includes physical injuries and fatality, involvement in further violence, health harming behaviours (e.g. alcohol and drug use and smoking), and mental health problems (e.g. post-traumatic stress disorder, depression, and anxiety disorders)(6).

Box 1: Definitions of Violence from the World Health Organization (7)

Violence: The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.

Interpersonal Violence: Violence between individuals, including family and intimate partner violence (child maltreatment; intimate partner violence; and, elder abuse) and community violence (youth violence; assault by strangers; violence related to property crimes; and, violence in workplaces and other institutions).

Youth Violence: Violence that occurs among individuals aged 10-29 years who are unrelated and who may or may not know each other. It generally takes place outside of the home. It includes a range of acts from bullying and physical fighting, to more severe sexual and physical assault, to homicide.

1.1. Youth Violence in England and Wales

While the overall level of crime has reduced across police forces in England and Wales, the volume of violent offences has risen since 2014, including knife crime, gun crime and homicides (1). More specifically, police recorded incidents of 'violence against a person' have increased by 121% since 2014, including a 45% rise in 'violence with injury' (8), 35% increase in firearm offences, and an 89% increase in offences involving a knife or sharp instrument (9).[1] What's more, the Office for National Statistics (ONS) estimate that only 38% of violent incidents are reported to the police (10), demonstrating how widespread and pervasive violence is within society.

Young people are disproportionately affected by violence, both as victims and perpetrators. The Crime Survey for England and Wales (CSEW) report that children and young people under the age of 25 years are offenders in 48% of violent incidents, 42% of 'violence with injury' offences and 44% of violence which result in wounding (for ages 25-39 years, this is 42%, 49% and 52% of offenders respectively)[2] (10). Furthermore, homicide is more prevalent in 16-24 year olds, with a consistently higher number of deaths than any other age group, each year (11).

Within the UK, there is an extensive effort to tackle youth violence, through investment and allocation of resources to tackle county lines and drug misuse, enhance early intervention and prevention, support local communities and partnerships, and strengthen law enforcement and the criminal justice response (1).

The Home Office Serious Violence Strategy emphasises that law enforcement alone is not sufficient to tackle serious violence, but rather, a multi-strand approach is needed which incorporates partners across sectors and engages local communities (1). Furthermore, early intervention and prevention is fundamental to this approach, preventing individuals from committing violence and being drawn into exploitation by providing timely interventions at a 'teachable moment', and building resilience and positive alternatives to violence (1).

In 2019, the Home Office established Violence Reduction Units (VRUs) across 18 police forces in England and Wales, with the aim to provide leadership and the strategic coordination of all relevant agencies. The VRUs seek to employ a 'public health' approach to tackle serious violence and its root causes, by using data and evidence to target interventions. Each VRU has invested in early intervention and diversionary activity to prevent individuals from engaging in violence and wider criminal behaviour (i.e. gateway offences such as robbery and drug offences), and supporting those involved in violence to make positive changes and reduce the risk of further harm. These interventions often seek to address the risk factors of violence at an individual, interpersonal, community and/or societal level, while also promoting protective factors.

[1] Due to changes in police counting rules brought in by the Home Office in July 2013, data is presented from March 2014 onwards. The volume of police recorded offences are: 1,791,757 incidents of violence against a person (YE Sept 19); 542,950 incidents of violence with injury (YE Sept 19); 6,622 offences involving a firearm (YE March 20; excluding air weapons); and, 46,348 offences involving a knife/sharp instrument (YE March 20)

[2] CSEW offender percentages exceed 100% because there can be multiple offenders. Percentages usually equal ~110%

1.2. Hospital-based violence prevention initiatives

Many VRUs have invested in hospital-based interventions that identify and respond to individuals seeking help with violence-related injuries. Healthcare services, particularly hospitals, are especially burdened by the consequences of violence, with a high volume of individuals requiring treatment for violence-related injuries. The National Violence Surveillance Network (NVSN)[3] estimated that 187,584 people received emergency treatment across England and Wales in 2018 for violence-related injuries (12), which has considerable cost and resource implications. In Wales alone, violence is estimated to be costing health care services approximately £205.4 million a year (see box 2 for further information) (13).

Box 2: The cost of violence to health care services in Wales

It is estimated that the consequences of violence cost the healthcare system in Wales £205.4 million a year; this includes £46.6 million in short term costs, which incorporates the costs of ambulance call outs, ED attendances, emergency hospital admissions, treatment costs and follow-up primary care (e.g. GP appointments); and, £158.8 million in longer term costs for the psychological impact of violence (e.g. counselling) resulting from anxiety and depression, alcohol and illicit drug use (13).

Although health services are providing care to a high volume of individuals involved in violence, this offers professionals a unique opportunity to engage and support patients, and intervene to prevent further harm. This is particularly important given the high level of violence which goes unreported to the police, thus reducing the opportunity to provide victim support, and implement preventative measures; for example, research in South Wales identified that 59% of ED assault attendances were not known to the police (14).

What's more, there are multiple risk factors underpinning exposure to violence, and as a result, individuals presenting at ED with injuries resulting from interpersonal violence are at a greater risk of re-injury, being arrested for perpetrating violence, and homicide (2). While health care professionals are well placed to identify victims of violence, it seems that often patients are discharged with limited support or follow-up to address the cause of injuries or wider needs of the patients presenting with violence-related injury, thus, the risk factors of violence are not addressed following injury (2).

Hospital-based violence prevention initiatives have been established and are currently operating in the UK, including Scotland, London and West Midlands (see box 3 for an overview of different models). The Home Office endorses hospital-based interventions, such as Redthread, in tackling serious violence, as they offer the opportunity for professionals to intervene with children and young people at what is considered a 'teachable moment', when they may be more willing to listen to professionals and engage with services.

[3] The National Violence Surveillance Network has over 100 (types 1, 2 and 4) Emergency Departments in England and Wales providing data on violence-related attendances on an annual basis.

Box 3: Examples of hospital-based violence prevention models established within the UK

Redthread youth violence intervention programme: In partnership with the Major Trauma Network, Redthread runs the youth violence programme in 8 hospital EDs across London and the Midlands. Youth workers within the ED engage with children and young people who are victims of assault and exploitation (aged 11-24 years), to encourage and support them to make healthy choices, and to disrupt the cycle of violence.

Oasis youth support violence intervention: Youth workers are located within the ED of St Thomas Hospital, to divert young people away from violence, including knife and gang crime. Children and young people aged 12-24 years, living in Lambeth and Southwark, can be referred to the service following attendance to the ED due to violence and aggression.Youth workers will provide one-to-one support to help explore the reasons for their referral and identify areas of personal development. Further support and opportunities can be provided by the Oasis youth support service, including music, sports or arts programmes, or volunteering and work experience. The service will also signpost young people to external services, including careers guidance, education and employment courses, housing, and support for mental health.

Hospital navigators: In Scotland, hospital navigators have been embedded into the EDs of seven hospitals since 2015. The navigators engage with patients in the ED who are affected by violence, and provide community outreach and access to community-based services. The service aims to enable patients to make positive changes in their lives, which in-turn will break the cycle of violence and ease the pressure violence places on the NHS. The navigators have diverse backgrounds, but all have lived experience of violence and/or vulnerability. The service is delivered by the charity 'Medics Against Violence' in partnership with the local NHS Trusts, and supported by the VRU and Scottish Government.

1.3. Tackling youth violence in South Wales: A hospital-based intervention

South Wales Police was one of the 18 forces to receive funding to establish a Violence Reduction Unit. While the Unit receives funding to reduce violence in the South Wales Police force area, the Unit operates on an all Wales blueprint. The Wales Violence Prevention Unit (VPU) is a multi-agency team which comprises partners from a range of key organisations, including the Police, Police and Crime Commissioner's (PCC) teams, Public Health Wales, local authorities, education and voluntary sector organisations. One of the key objectives of the Unit is to commission, adopt and fund interventions that prevent all forms of violence in Wales through a public health approach. This includes a hospital-based violence prevention team, which has been developed and implemented within an ED in South Wales.

The NHS Violence Prevention Team (VPT) was established in October 2019 and is solely funded by the VPU at no cost to the NHS. The team comprises of a qualified nurse and a violence prevention advocate situated within the ED at the University Hospital of Wales (UHW), and a community-based caseworker. The caseworker is funded by the VPU as a designated resource to the hospital, but works as part of the wider Action for Children Side Step programme[4].

The role of the VPT is to increase the reporting of violence-related injuries to the police, and to provide support to patients to address their vulnerabilities and risk factors for violence victimisation and perpetration (see Appendix 1 for the theory of change). More specifically, the team deliver advice, support and guidance to patients who have experienced violence with injury, with the aim of engaging with those injured whilst they are in hospital (at the point of crisis), and to promote movement away from violence by encouraging engagement with support, intervention and wider services.

[4] The Action for Children Side-Step programme is a serious organised crime early intervention service established in Glasgow (2013) and rolled out to Edinburgh, Newcastle and Cardiff in 2020, with funding from the National Lottery Community Fund.

The objectives of the VPT are:

1. To increase identification of patients with injuries resulting from serious violence, and enhance safeguarding responses and police reporting;
2. To engage with patients of serious violence-related injuries, and provide holistic support that addresses wider risk factors of engagement in violence;
3. To promote a public health approach to violence prevention within healthcare settings, and engage with staff to enhance their knowledge of violence; and,
4. Establish referral processes and pathways to support for patients with violence-related injuries to receive longer-term follow up support to prevent future engagement in violence.

1.4. Evaluation aims and objects

A process and outcomes evaluation of the VPT was conducted. The evaluation explored the development and implementation of the role of the VPT within the ED, the nature of the support provided to patients, and the sustainability and potential wider roll-out of the service in Wales.

The objectives of the evaluation are:

1. To understand the role of the VPT in supporting victims of violence-related injury;
2. To assess the efficacy of the VPT in addressing the needs of patients and preventing future violence-related injuries;
3. To assess the effectiveness of the implementation and delivery of the VPT within the ED, and identify any developments to further enhance the role of the team;
4. To explore the benefit of the VPT, and consider sustainability of the model, potential for scale up, and roll-out of the intervention to other health settings in Wales.

Section

2

Methodology

2.0. Methodology

The service evaluation utilised a mixed methodology to assess the delivery and outcomes of the VPT through an online survey and interviews, and using service-level data. Data was collected with staff working within UHW, as well as service providers, key partners and stakeholders (collected February-April 2021). This service evaluation was reviewed and approved by the Research and Development (R&D) offices of Public Health Wales and Cardiff and Vale University Health Board (UHB).

Questionnaires

An online survey was completed by both clinical and non-clinical staff who work in UHW. The survey explored participant's experience of working with patients with violence-related injury, including the challenges experienced and additional resources needed, their experiences of working with the VPT and the impact of the VPT on responses to patients with violence-related injury.

In total, 54 surveys were completed[5] (see Appendix 2 table 1 for a full breakdown of participant demographics), including representation from the ED (80%, n=43), safeguarding (16%; n=9) and the major trauma service (4%; n=2). This sample consisted of a wide range of job roles, including nursing roles (n=31), doctors (n=10) health care support workers (n=13), and other (e.g. administration; n=6).

Interviews

Semi-structured, one-to-one interviews were conducted with the VPT, professionals involved in the development and implementation of the VPT, clinical staff, and key partners (e.g. police; n=12).

The interviews explored: participants experience of working with victims and/or perpetrators of violence; the role of the VPT within the hospital and the support they provide; the development and implementation of the VPT; and, service sustainability, and potential for scale-up and wider roll-out of the VPT.

Participants were invited to be interviewed by email. The interviews were conducted via Microsoft Teams, and recorded for transcription purposes.

Service level data

Anonymised data was provided by the hospital-based VPT and caseworker, for a period of a year (April 2020-March 2021). The hospital-based VPT provided data on all patients who attended the ED with violence-related injury, including their vulnerabilities and support received by the VPT. Similarly, the caseworker provided data on the individuals referred to the service through the hospital, and their vulnerabilities, risks and work completed with individuals the service supported.

Analysis and report structure

Descriptive analysis was conducted on both the survey and service-level data using Microsoft Excel. A thematic analysis was conducted on the interview transcripts and the open responses from the survey.

The survey and interview findings are presented alongside each other. Service-level data is shared throughout the findings, with a full report in Appendix 3.

[5] 64 surveys were completed, however, 10 surveys were removed from the sample because only the demographic questions had been filled out.

Section

3

Findings

3.0. Findings

3.1. The role of the VPT

Participants reported that the ED is an important place to identify and respond to patients with violence-related injury, as it provides a safe space for victims to disclose abuse and receive support. For individuals involved in serious violence, attendance to the ED offers a 'teachable moment'; participants described this as a time when the patient is particularly vulnerable and in need of help, and as a result, professionals have the opportunity to have a positive impact on an individual's life to prevent further involvement in violence.

"Often what we find is, and this will be the same for any victim, whether it's abuse, neglect or a violent injury, when they're in hospital often they feel safe. So it's a window of opportunity."

Interview 4, Safeguarding team

However, clinical staff and strategic leads reported that ED's do not typically have the necessary infrastructure for clinical staff to provide care beyond the medical needs of the patient, including time and resources to provide support.

"A&E departments were usually the main place where we would be exposed to the violence or the allegations. And then it was about teams being busy and not having that infrastructure I suppose to follow up once something had been identified. And somebody having the time to be able to follow up which is important in a health service."

Interview 10, Safeguarding team

During interviews, participants reported that the VPT work within the ED as a designated resource to respond to the wider needs of patients with violence-related injuries. Importantly, the role of the VPT is focused on identifying patients who present to the hospital with injuries which have resulted from violence; to engage and offer support to address their vulnerabilities; and, to increase reporting of violent incidents to the police. Within the hospital, the VPT will seek to engage with any patient presenting with non-domestic violence-related injury[6]. This includes patients presenting with injuries from low-level assault (e.g. a punch to the face) and self-inflicted injury (e.g. from punching walls), to more severe injuries, including stab injuries, gunshot wounds and significant head injury. The team does not have a specific criteria, which allows the team to identify patients presenting with lower level harm, and to put support and interventions in place to address needs before harm and/or involvement in serious violence escalates.

"Once they're stabbed, you know, that's the worst possible outcome that could happen to them but if we could get to them when they're just presenting with minor injuries then I feel that that is a much better outcome."

Interview 2, Nurse team

The hospital-based service will work with patients attending the ED of any age, and since the hospital was established as a Major Trauma Centre (MTC)[7], they support patients from locations across South Wales, West Wales and South Powys.

"So it's one of the skills set that we have is being able to work with anyone that comes through the door. It's about knowing the best way to interact with them and the services that then go on to support them. So we made a point of not having an age limit for that purpose."

Interview 3, Nurse team

[6] The hospital has IDVAs working within the ED to interact with victims presenting with injuries caused by domestic abuse. As such, the VPT does not engage with victims of domestic abuse unless the abuse is disclosed after the victims have started to engage with the VPT, in which case, the team will work alongside the IDVAs.

[7] The hospital received MTC status August 2020, ten months after the VPT was established within the ED.

While the hospital-based VPT (the nurse and advocate) have a wide remit, the caseworker has a more specific referral criteria. This caseworker offers intensive community-based support to children and young people aged 11-24 years old who have attended the ED with injuries resulting from serious assault, and who are involved in serious organised crime and drug related activity, or where there are signs of criminal exploitation. This caseworker seeks to build resilience to enable the young people to be diverted away from further involvement in serious violence and organised crime. This model allows the caseworker to provide longer-term intensive support to the most at-risk individuals, while enabling the hospital-based VPT to offer all patients involved in violence some form of support and intervention, at the earliest opportunity.

"[The caseworker] picks up those really high risk patients, allowing us to see a lot more patients and kind of see everyone instead of just having to limit it like the other interventions have done across the UK. So I think that's invaluable to us."

Interview 3, Nurse team

3.2. The support the VPT provide victims of violence-related injury

The interactions between the VPT and patients, and the level and type of support offered varies between patients, with the service delivering bespoke care and support. The VPT adapt their approach to the patient's needs, however, typically the team will initially engage with each patient, attempt to establish a relationship, conduct a risk- and needs-based assessment, and then identify services for the patient to be referred in to.

3.2.1. Referring patients into the VPT

During interviews, it was reported that patients will initially be referred into the hospital-based VPT by clinical staff. For patients who meet the criteria for community support, the team will direct them straight on to the caseworker to conduct an assessment.

Patients can be referred into the VPT through a number of different channels. The VPT has developed adult and paediatric referral forms for staff to use. Due to the large footfall within the ED, paper-based forms are located throughout the department and relevant treatment areas and wards (e.g. poly trauma unit), and are accessible for doctors and nurses to complete at any point during the patient's journey through the hospital. These forms are typically completed if the VPT are not on shift when the patient attends the department.

Staff are encouraged to refer patients in a variety of formats, including email, telephone, post-it note, or through face- to-face contact if the team are present within the ED. These less formal interactions are the preferred method of referral for the VPT and staff, reducing the level of additional work on the clinical staff treating the patients.

"The easiest referral ever, just give them a ring or drop them an email and that's what you want. The last thing anybody needs is like a big, complicated proforma to fill in and get to the right place [...] and they're pretty good, they get back to you within the day, always."

Interview 9, Clinical staff

Furthermore, when patients are 'booked-in' to the ED (registered), a set of questions are asked which can flag up patients with violence-related injuries. The reception staff will, at times, notify the VPT of a patient that has not been picked up, or raise concerns from the information a patient has shared with them. In addition, the VPT will monitor the ED system to identify patients themselves, which offers a 'safety net' that prevents patients from being missed.

"They're often on top of this, so we often don't have to ask them to get involved."

Interview 8, Clinical staff

The VPT also accept referrals by email from the Health Board Minor Injuries Unit (MIU); the VPT established this referral mechanism to allow lower harm injuries to be captured, thus, further enabling them to identify victims of violence at an early opportunity.

"If they see a patient with this certain injury, the referral goes to us straightaway, so we're in their referral pathway now which is great."

Interview 3, Nurse team

3.2.2. Point of interaction with patients

The VPT engage with patients at different stages of their journey as a patient, depending on the type and severity of their injuries, what time and day they attend the hospital, and the longevity of their hospital stay. More specifically, if the injuries are not life threatening, the team will seek to engage with the patient as soon as they become aware of their presence within the hospital, providing immediate support and response. If the team are on shift at the time the patient comes into the ED, they will meet with them there and then. However, if the patient is discharged before the team become aware of them (i.e. if the team are not on shift), the team will follow-up with a phone call, carry out an assessment and see if there is any support needed. Prior to COVID-19, the team would offer face-to-face interactions with discharged patients, in outpatient clinic for example.

"So sometimes all it is, is someone phoning up and making sure that they're okay after their incident. We've had some really positive feedback from people just going, "Oh, thanks for checking on me and making sure that I'm okay", because sometimes that's all that they need."

Interview 3, Nurse team

For patients with more severe injuries, the VPT would wait until the patient has received medical intervention and is clinically stable before offering the service. These patients are usually admitted into the hospital, and as a result, the team will engage with them on the wards, and conduct assessments over a period of time to reduce the intensity of those interactions. Similarly, the caseworker will engage with patients either in the hospital or within the community, utilising the hospital-based team to determine the most appropriate time to interact with the patients. Working with individuals who are admitted as inpatients offers the opportunity to deliver more intensive support.

"They will often see them [patients] whilst they're still in the emergency unit being assessed. Depending on the injuries that they have, sometimes they won't be able to speak directly with the patient because they may have come in with life threatening injuries, so obviously the treatment that they receive is more important than anything else at that particular point in time. But they will try and engage with the victim as soon as possible, so that may be in the EU or maybe when they're more stable on a ward area."

Interview 4, Safeguarding team

3.2.3. Establishing relationships

The VPT take the time to establish relationships with the patients they support, and in many cases, their family members. The team reported that it is integral to take the time to build a relationship with patients in order to break down barriers, and reflected that often, individuals involved in violence are distrusting of people and services, especially the authorities. In particular, children and young people who are involved in gang activity are too frightened to speak out and disclose to professionals. Therefore, relationships need to develop, and trust established before they can work with the patient to address the risks. To achieve this, the hospital-based VPT will seek to engage and build a rapport with the patient in less formal environments, by taking them for a beverage off the ward for example.

"Often the victims have got very little trust of anybody in authority. You know, because if it's gang related etc, they won't talk, they don't make any disclosures, they're frightened of the police and children services etc. So it's trying to break down some barriers with them, that's the first thing."

Interview 4, Safeguarding team

Within the community, the caseworker will seek to establish relationships by providing individuals with fun activities, which includes taking them for food, or out of area (e.g. to the beach). In addition to establishing a relationship and the trust needed to enable them to start working towards achieving change, the caseworker reported that this gives them time away from the dangers in their community and having to 'look over their shoulder', whilst also allowing them to see outside their own housing estate to envisage a different future.

3.2.4. Patient assessments

The hospital-based VPT and caseworker complete their own needs- and risk-based assessment for all patients who consent to engage with the services. The VPT will collect information on the patient from a range of different sources to inform their assessments; the hospital-based VPT have access to the NHS patient record systems, including PARIS and Clinical Portal, which enables them to gather any relevant information on the patient, including whether they have had any previous violence-related injuries, and if any domestic abuse Public Protection Notifications (PPNs) have been submitted to the local authority. Furthermore, if considered necessary, the team will contact social services, the police, youth justice and/or National Probation Service (NPS) to find out whether the patient is known to them and if there is any information they need to be aware of; this information will be gathered by the caseworker if the patient meets the criteria for community support.

The hospital-based VPT have developed their own assessment, which has pulled together questions from a range of pre-existing assessments, including St Giles[8], domestic and sexual violence assessments, child exploitation and child protection screening tools (e.g. the SERAF[9]). This combined assessment allows the team to ensure they capture all the information partners are likely to need; this includes information on the incident, while assessing a wide range of needs, risks and safeguarding concerns, and actions agreed with the patient.

"Our aims are to engage in a conversation with these individuals [patients] to try and identify whether there are any support needs. These clients don't always know that they have support needs, so our engagement is different for every single person depending on where that conversations goes we can identify certain needs."

Interview 2, Nursing team

This assessment was initially completed with patients on a written document, however, the nurse and advocate have memorised the assessment and now conduct it through less formal interactions with the patient. This prevents them doing paperwork and being seen to 'tick boxes' in front of the patient, and allows them to gather the necessary information through casual conversations.

However, once the information is gathered, it is written up into the patient's clinical notes and included in their case notes for other staff to be aware of.

In addition to the initial assessment carried out, the team will complete more extensive risk assessments for children under the age of 18 years who are placed on a ward. At times, children with violence-related injuries (particularly adolescents) will be treated in adult treatment areas, therefore child protection procedures and a safety plan needs to be established to keep the child safe within the hospital.

[8] A UK-based national charity which supports vulnerable people to achieve a more positive future through support, advice and training. The service provides support to individuals: involved in/ at risk of exploitation; who face unemployment and poverty; or, who are in the criminal justice system. The service individuals with similar experiences to provide peer-support.

[9] Sexual Exploitation Risk Assessment Framework (SERAF)

The caseworker conducts their own assessment of children and young people referred to them, either in the hospital (if appropriate), or following discharge. The team will engage with partner agencies to gather information on the child and family, including social services, youth justice and/ or probation, to ensure they have up-to-date information and that they do not miss anything. A contextual safeguarding assessment is carried out, which explores vulnerability and risk factors, resilience factors and strengths, progress achieved, capacity to safeguard, the family/ home situation, peer relationships, school/ workplace, and online risks; this is considered an on-going and adaptable assessment.

"You can share that with other partners if you're working in partnership with an individual but then you can always regularly update it."

Interview 11, Caseworker

3.2.5. The nature of support provided to patients

The support provided to each patient will vary depending on their vulnerabilities, with tailored support provided based on the needs identified during assessment (see box 4 for examples of support provided). By utilising external agencies and community-based services, the VPT are able to offer a wide range of support to address multiple needs.

"We do a needs risk assessment, assess the needs and then we discuss with them what kind of support options they'd like and then each individual patient then is supported differently. So some patients need housing support, some need emotional support, mental health, some need just the basics as in registering with GPs, getting identification to register with GPs, it completely varies from patient to patient."

Interview 3, Nursing team

Box 4: Examples of needs-based support the VPT provide to patients

Family relationships: Many patients have difficult family relationships or are disconnected from their parents, and some parents /guardians experience constant worry for their child's safety, particularly when they leave the house. The VPT will provide family support following injury, reconnecting patients with family out-of-area, providing intervention to improve patient communication skills or by putting parental support packages in place for them (e.g. through Victim Focus, children's services). The VPT reflected that there is substantial support available for children, however, they consider it vital for parents to also be supported through the process to ensure they can then support their child.

Housing: Many adult patients experience housing concerns, living in unsafe and unsanitary conditions without water or heating, food or sustainable income. The team link in with housing associations, councils and the homeless nurse to ensure patients have safe and sanitary housing provisions. This includes supporting patients to move out of area to re-establish family relationships or community connectivity, which has included working with immigration to support a patient to move out of the country.

Drug and alcohol abuse: For patients who are assessed to have concerns relating to drug and alcohol use, the team will submit referrals to inpatient drug and alcohol services (for those who are admitted into hospital for treatment), and community services for patients once they have been discharged.

Education: The VPT will engage with schools, and liaise with school welfare officers, following incidents of violence involving a school pupil. They will provide insight into the child and their vulnerabilities, or to support a child's re-engagement back into education.

Criminality: Intelligence provided by patients is shared with the police and other relevant agencies confidentially. Patients involved in criminality (e.g. serious violence and organised crime) are referred to other interventions operating in the area. The VPT will also support patients to engage with the police and, when necessary, through court, and aid officers investigating incidents.

In addition to providing needs-based support, the caseworker provides both 1:1 support and group work, and deliver a range of specific interventions, including those which address emotional regulation, self-esteem, relationships and behaviour. The caseworker also provides emotional and practical support to the parents/guardians, and provides the young person with access to sports-based interventions. The caseworker will further engage with children and young people to provide them with education on a range of subjects, including healthy relationships, sexual health, the consequences of involvement in criminal activity, and effective communication.

The caseworker also seeks to promote a more positive future with children and young people, providing them with an insight into an alternative future, to consider the steps to achieve that future (e.g. return to education), providing activities or opportunities to utilise and enhance their strengths or upskill them (e.g. involvement in sports or volunteer work), and to support them into employment (e.g. CV development).

"Creating different opportunities outside of an estate mentality."

Interview 12, Caseworker

At times, the caseworker will extend the support to the wider family, particularly siblings, who may also be at risk.

The caseworkers reflected on the importance of 'fun' for children and young people, which can be used to further promote a positive future, or facilitate the caseworker in opening up channels of communication and deliver education to support diversion.

"Sometimes the biggest intervention is for them just to experience being a child and enjoying themselves and feeling like, "I like this, I don't want to go back to that". Sport is a big intervention as well for some of our young people. Music, they love music but that's also a really good intervention and talking point because of what they listen to. Because some of what they listen to they don't realise has a huge influence on how they can behave, especially with some of the drill music."

Interview 12, Caseworker

Case Study 1**: Sean**

Sean, a 38 year old male, attended the ED with injuries to the face and chest following a knife assault. The patient had previously attended the ED six times, the most recent visit was following an assault which caused a significant head injury, however, Sean had refused to engage with staff and discharged himself against medical advice.

During this current visit, Sean was admitted into hospital, and was an inpatient for eight days. During his time in hospital he often displayed challenging and problematic behaviours (e.g. agitation and aggression), and as a result, security had frequently been called to manage these behaviours.

Sean consented to a referral to the VPT. An assessment was carried out where Sean disclosed he was homeless, and was currently living with a friend who he supplied drugs to in place of rent. Sean's injuries were caused by his housemate after a disagreement regarding drugs.

Sean was also using heroin, and distributed spice to fund his addiction. The medical staff were not aware of Sean's addiction, however, Sean was displaying symptoms of withdrawal during the assessment, which potentially explained some of the behaviours he was displaying.

Following assessment, the VPT contacted the health board housing officer to arrange safe accommodation for Sean to be discharged to. The VPT also arranged for the nursing staff on the ward to refer Sean to the drug and alcohol liaison nurse. At a later date, Sean also disclosed that he would like to return to his home country; with consent, the VPT contacted the Chief Immigration Officer linked to the VPU, and started the process for voluntary deportation.

Frequency of engagement

The frequency and duration of engagement with patients will vary based on the patient's vulnerability, the number and type of unmet needs, the extent to which patients are willing to engage, and the relationship which has been built.

For the hospital-based VPT, most patients will usually have very minimal input with just one or two interactions with the team, which can include a follow-up text from the team with their contact details, a phone call, and in some instances, onward referrals. However, some patients need a greater level of support, thus, will have more frequent contact and be maintained on the caseload for several weeks. The team will continue to support inpatients until they are discharged.

"Sometimes it is just as little as having that phone call, making sure that actually their injuries are healing okay, it's the reassurance that their head injury seems to be going the right way but they can always come back to us if they want."

Interview 3, Nurse team

The VPT are only able to maintain a relatively small case load of patients requiring additional, longer-term support. This will usually be maintained for patients who are on waiting lists for services, or when there are no suitable services to address vulnerabilities but the patient is too high risk to completely disengage with.

For individuals who are referred to the caseworker, the hospital-based services will have very minimal contact or involvement. However, the caseworker will engage with these patients two or three times a week. To maintain frequent contact with young people and deliver high-intensity support, the caseworker can only hold a caseload of five young people at a time. There is a potential for some service users to be held on the caseload for several months to allow the service to persevere with children and young people who do not wish to engage.

"We found perseverance and the right approach [to engage]- It's taking some time whereas a lot of service providers try it for a month- And I had that in my previous roles, four times of trying, they're not engaging, right, close that case down and go into the next one."

Interview 11, Caseworker

Case Study 2: **Mike**

Mike is a 19 year old male who attended the ED after being stabbed by a group of males in a pre-planned assault outside his home. A referral was made to the VPT which was directed straight to the community caseworker.

Following release from hospital, the caseworker discussed the service with Mike and the support that could be provided. An assessment was carried out and information was gathered, which ascertained that Mike was currently unemployed, and had Autism, an audio processing disorder, and Attention Deficit Hyperactivity Disorder (ADHD). Mike had previously been in prison and was under investigation for further offences at the time of the assessment. Mike also demonstrated low levels of self-esteem, motivation and self-confidence, and was a heavy cannabis smoker. The caseworker assessed Mike as being highly influenced by others, with a strong sense of loyalty, which at times was harmful to himself.

While Mike consented to receive the service, he would not engage with his caseworker, stating the support was not needed. However, the caseworker continued to reach out to Mike and tried different approaches to try and connect with him. After two months, Mike unblocked the caseworker's number and agreed to meet them. Mike informed the caseworker that following the stabbing he had become too scared to leave his home (where he lived alone), and going out caused him to become physically sick.

Mike also shared the challenges he has communicating with people, particularly those his own age.

The caseworker supported Mike to visit the GP, and requested the doctor to make a referral to the Integrated Autism Service (IAS). Mike has since started to work with IAS, and engage with professional support. The caseworker now meets with Mike twice a week, and continues to build an effective relationship through activities, such as cooking, and identify any other needs they can address. While Mike is not ready to reduce drug use at this point, he is open to discussing the underlying problems, and to eventually work towards it in the future when home life is more settled.

Managing risks

Many patients who attend the ED remain at a significant risk, particularly those involved in serious organised crime or gang related violence. Subsequently, there is a risk of people entering the hospital to cause further harm to the patient. Information on the risks, and known associations will be gathered through the police, VPU team (i.e. police and probation), hospital staff, and through the safeguarding team (who routinely meet to discuss patients). The VPT will then engage with the hospital security, on-site police and ward staff to better manage these risks, making them aware of the patients who they have concerns for and to put measures in place to mitigate risk (e.g. ensuring patients who are at risk to each other are kept separate).

"We go to safeguarding meetings and things like that, and all the professionals will then discuss, "Well that person's linked to that person, that's their brother," and all that kind of stuff. You then build a picture in regards to these attendances, and then we have had a professionals meeting then to discuss these children and how to then protect them and all that kind of stuff. But without us [VPT] being in the department, a lot of that information would be missed because of the siloed working."

Interview 3, Nurse team

Similarly, the community caseworker has a significant role in managing the risks to the children and young people involved in serious violence, as well as to themselves. To manage these risks, the caseworker will make contact with established links in the police, youth justice services, children's services and other relevant agencies to see if the child and young person is already receiving support from the service, and to gather relevant information. For example, the caseworker has strong links with the Police Child Exploitation Team and Youth Offending Team, who they directly liaise with to share information and flag any safety concerns and risks, and gather any further information that has been obtained.

"We run the daily flag update from the police as well. So then if our young people crop up on that, then we've got that evidence as well, that will inform us more to the risk assessment and the contextual side of it, and more about how I safeguard the staff and safeguard the young person as well."

Interview 11, Caseworker

If social services are already involved they would typically have a safety plan in place, otherwise, using the information gathered, the caseworker will conduct the risk assessments and establish safety plans. These plans include measures taken to manage lone working practice, including regular check-ins, and in situations when the risks are considered too high for 1:1 support, joint visits will be carried out. However, the caseworkers reported on the challenges of managing these when working with children during the early stages, particularly for those who are not known to services and where there is little information available on them.

"So if a young person has a threat to life as well, you never do that visit on your own with them. When it comes to weapons and things like that, it's being very honest with them, "I'm expecting you to be honest and not come out tooled up when you're with me. I'd rather you not carry weapons when you're not with me but when you're with me, you know, you need to be above reproach."

Interview 12, Caseworker

3.3. Development and implementation of the VPT

3.3.1. Establishing and setting up of the VPT

The VPT was established by the safeguarding lead within the Cardiff and Vale University Health Board. The Wales VPU, particularly representatives from the South Wales PCC Office, supported the development and implementation of the service, and has continued to have an integral role in service delivery.

During the interviews, the participants reported that there had been an appetite to establish a VPT within the hospital for a number of years. The work delivered in Wales on adverse childhood experiences (ACEs) and trauma-informed approaches (e.g. the Early Action Together programme)[10] had provided a strong rationale for needing a service that can respond to the wider needs and vulnerabilities of patients presenting with violence-related injuries. However, clinical leads reported that while they gained the support of the Health Board Chief Executive and Chair, they were unable to provide the level of funding needed to set up the service.

"In some way I was pushing against an open door but there just wasn't an awful lot of money behind that open door"

Interview 8, Clinical staff

[10] The Early Action Together Programme is a Wales Wide programme funded by the Home Office to transform how police and partners respond to vulnerable individuals. This programme set out to establish an ACE- and trauma-informed whole systems approach to vulnerability by enhancing access to early intervention and prevention: https://www.aces.me.uk/

The VPU provided the funding necessary to establish and pilot the service. The safeguarding team reported that, through the establishment of existing programmes of work (i.e. the hospital IDVA service), there were strong relationships between the Health Board safeguarding team and Police, and a shared understanding of the type of model needed within the department. This put the safeguarding lead in a 'strong position' to develop the model, and as a result, the VPT was set up with relative ease, eliminating the need for a consultation process.

Furthermore, staff secondment opportunities were created (within the Health Board) which allowed staff to be recruited and the service to be set up within a very short timeframe. The service was able to start receiving referrals within a month of the team being in post.

"They hit the floor running to be honest. I think they started in the October [2019] and by the end of November they'd gone live."

Interview 4, Safeguarding team

However, the wider Side-Step programme (funded by the National Lottery) was not established until several months later, and as a result, the caseworker assigned to the hospital (funded by the VPU) was not embedded into the service until the following summer (June 2020). In the meantime, referrals were directed to other youth-based services in the area.

Once in post, the nurse and advocate were given the autonomy to develop the service and shape how it was delivered. The team spent the first month developing their knowledge and putting the necessary processes in places; the team visited other hospital-based violence prevention teams (e.g. Redthread) to observe service delivery (e.g. what did/did not work well), reviewed the health 'violence with injury' data, carried out desk-based research on services available, networked with partners (e.g. community voluntary services), and developed the required paperwork (e.g. referral forms).

The VPT reported that they were initially provided with the outcomes the Home Office defined for all VRUs to achieve (see box 5), but felt that, based on the demography of victims attending the ED, focusing on achieving these objectives would prevent the service from meeting the demand within the ED. For example, the data highlighted that 60% of knife injuries presenting to the ED were from adults aged >25 years. As a result, the team wanted to establish the service based on the needs of the area and population it was serving, and create aims that were more achievable and easy to measure in a shorter timeframe for monitoring (e.g. weekly, monthly and quarterly monitoring).

Box 5: Home Office VRU outcomes:

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

The VPT reported that the Wales VPU have played an integral role in establishing the service, and its continued delivery. In particular, the VPU partnership strand are always available to offer support, to respond to any concerns and manage any problems the team experience: "they will try and find support that we need by all costs if they can" (Interview 2, Nurse team). For example, the VPU will address any concerns the team have with police practice, will work to overcome barriers to accessing support for patients and help to identify services where there are gaps. The VPU have also supported the VPT by convening multi-agency meetings to respond to major incidents and coordinate a response to reduce risks of further violence. Monthly meetings are held between the VPT and VPU to review the referrals received, discuss the support provided and progress achieved.

3.3.2. Effective service deliver and promising practice

The interviews, survey responses and VPT data highlighted key facilitators for effective service delivery, and areas of promising practice. This includes the value of the experience and expertise of individual roles within the VPT, and the level and nature of both patient and staff engagement.

The roles of the VPT

During the interviews, all participants spoke highly about the roles selected to deliver the service, including the nurse and advocate operating within the hospital, and caseworker based within the community. These individual roles were viewed as beneficial, with each professional providing experiences which are unique, complimentary, and valuable to effective service delivery.

The nurse previously worked as a sister within the same ED, and had considerable experience treating patients with violence-related injuries. During the interviews, all participants reported that the nurse's experience in emergency care provided considerable benefit, breaking down barriers and enabling the service to better integrate into the hospital; this is important given the 'fast-paced' nature of the environment. More specifically, the nurse was known within the ED and had pre-established relationships with staff, and a good understanding of how the department operates, the structures within the hospital, the referral processes, and importantly, the 'patient journey' through the hospital and of the treatment they receive. This clinical knowledge was considered a benefit to the service, allowing them to understand the health needs of the patient, including the type of treatment received, and subsequently the impact this care has on the patient (e.g. on their ability to interact with people). Furthermore, participants reported that the nurse has a good understanding of the practicalities of working in the ED and the challenges staff face, which has allowed the team to adapt their service to offer flexibility to staff who experience significant pressures.

"The nurses are doers and they're on the shop floor, it's not like academically led it's more practically led and I just felt that we could do it, you know, if we had the right team together".

Interview 4, Safeguarding team

While the nurse has a comprehensive understanding of the internal processes within the hospital, the advocate is reported to have extensive experience of the processes external to the hospital. The advocate has experience working as an Independent Sexual Violence Advisors (ISVA) and an IDVA. This has provided her with the knowledge and experience of supporting individuals who are victims of violence and who have suffered significant personal trauma, including experience of completing risk- and needs-based assessments, and supporting victims through the criminal justice process. The advocate has the experience to network with partner agencies and community services to access support for patients, and to understand how third sector and statutory organisations (outside the hospital) operate.
The nurse and advocate have worked to upskill each other, with the nurse providing the advocate with the medical insight to engage with patients, doctors and the wider medical team (e.g. nurses). Similarly, the advocate has enhanced the nurses knowledge and understanding of support services, trauma-informed practices, and contextual safeguarding, allowing them to provide a 'wrap-around service'.

On the other hand, the caseworker has extensive experience working with children and young people, including those with challenging behaviour, who live in deprivation, are low academic performers, and who have lived in households with violence (e.g. domestic violence). It was reported that the caseworker has an understanding of the children's behaviour and wider needs, and the skills necessary to establish relationships with children and their parents and support children to make positive changes in their life.

"The caseworker from Action for Children has huge amounts of experience of working with the young people as a youth worker and again brings an added level of experience and understanding around those risk factors of young people."

Interview 1, Police

During the interviews, many of the participants raised that the roles within the VPT differ from other models delivered in the UK. In the VPT, the nurse and advocate operate in the ED while the caseworker remains community-based, whereas other models such as Redthread, place youth workers within the hospital. A couple of participants reported that they had initial concerns that patients would not be able to 'relate' or engage with the nurses as effectively as they could with youth workers. However, the participants all reported that the team interact well with the patients, and that the patients respond positively to them. Similarly, participants reported that the backgrounds of the hospital-based team provide 'credibility' to their roles within the ED and wider hospital, and has allowed them to establish relationships and develop trust among the staff. As a result, the hospital staff are viewed to be more receptive to the presence of the VPT and involvement with patients, and will actively engage with them for support. In addition, the nurse and advocate has enhanced the interactions between the caseworker and hospital staff. This has allowed the caseworker to better integrate into the hospital when attending to assess a patient, or in cases when there has been a major incident, to work within the hospital to provide support to assess and manage risk within the hospital.

"I didn't feel they were right and I'm the first person to hold my hands up and say I was completely wrong, they've done a great job [...] I don't know whether if you had somebody who came in as a stabbing and you had a youth worker who wasn't familiar with them, there might be a sense from the clinical staff that they were getting in the way, interfering."

Interview 8, Clinical staff

Patient engagement

The participants reported that the VPT has been successful in their engagement with patients. Participants reflected that patients typically have high levels of vulnerability, and often struggle to trust professionals and services. Engagement is considered integral "[...] because if you don't engage with them then you've got no chance of changing anything really."

Interview 8, Clinical staff

It was further reported that nurses will typically be the main point of contact for patients, and will have significant involvement in patient care. While the VPT do not generally provide emergency care to patients, the nurse within the VPT has, on occasion, provided medical care to support staff with challenging patients, and to enable them to establish relationships with high risk patients.

"I think they use that as a hook to get a bit more involved with them, so maybe become more trusted."

Interview 12, Caseworker

As a result, the patients are not viewing the VPT as an outside agency or another professional, which combined with a caring and compassionate response, allow the team to establish trusting relationships with patients. The caseworker reported that the nurses also facilitate the engagement between the patients and caseworker.

"Youth workers in the hospital I think is an incredible, brilliant idea but the nurse will always be the first point of contact anyway because they've gone in because they've been hurt."

Interview 12, Caseworker

Moreover, the nurses are fully embedded into the hospital environment, and as such, can access and engage with patients at any point, when appropriate. This allows the service to have less formal interactions with patients, and to provide support while they are an inpatient. This was considered highly valuable, allowing the VPT to maximise the 'teachable moment' with the patient, and to take a flexible and less intense approach to addressing their needs and risks.

"I found that they [patients] have been more open to talking to you in hospital because there's nobody around, they've got nothing else, they're hurt, so they're a little bit more willing as opposed to when they get out- they're a bit more hardened to who's watching, what your intentions are... "I don't need the support, I'm okay, I'm fine". Whereas in hospital sometimes it's a bit more like, "okay, yes, I've been stabbed, I do need help or, yes, I would like to get out of this."

Interview 12, Caseworker

The team have reported a high engagement rate, which has been supported by service-level data (see Appendix 3 for a full report on service demand and response). Over the course of the year (April 20-March 21), a total of 477 patients attended the ED with violence-related injuries, of which, 75% engaged with the hospital-based VPT for support, including 66% of patients attending the ED with injuries caused by weapons (see figures 2 and 3).

Figure 2: *Total number of patients with violence-related injuries who engaged with the VPT*

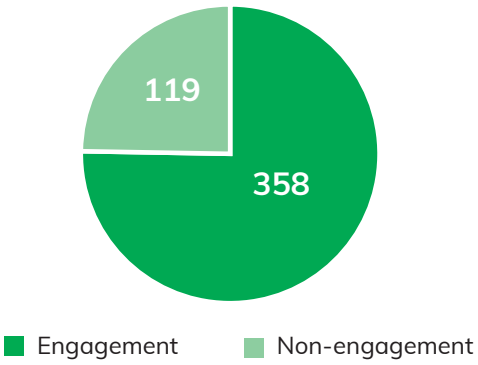
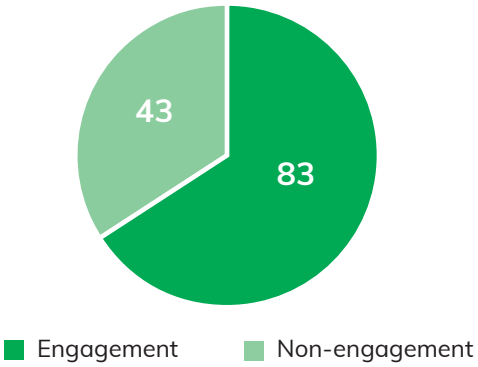


Figure 3: *Number of patients with weapon-related injuries who engaged with the VPT*



The interview participants reported that patients engage with the team who they typically would not expect to engage with services, reflecting that this is down to the perseverance of the team, and because "they'll do whatever they can within their nursing role to help patients in their recovery."

Interview 12, Caseworker

"What we found especially with our ones with like criminal exploitation and criminal background in regards to drugs and violence-related attendances, if you go back a few times they generally warm up to you and then engage and that's where the inpatient side of it is, if they're in we've got time to build up that rapport, you can generally get the engagement."

Interview 3, Nurse team

Similarly, the caseworker has reported children and young people to be engaging well, including those who have disengaged from all other services. The caseworker have received referrals for 40 patients since the role was established in June 2020, of which, they have supported 17 children and young people, with 10 assessed to have good levels of engagement (e.g. interacts weekly with the caseworker; see Appendix 3, table 8 for further information on engagement).

"What they're doing is engaging and that's the key thing for us, is that mostly all of our cases that have come to us have got a high level of disengagement with other service areas. So considering we've only been [operational] really [since] June last year, it's still early days and stuff. They're engaging well, they're starting to take part in sort of interventions that we provide."

Interview 11, Caseworker

Over the course of the COVID-19 pandemic, the VPT has been able to continue to operate, and maintain face-to-face contact with patients. Within the hospital, the VPT sit under the safeguarding team and have a vital role in enhancing safeguarding responses to patients presenting with violence-related injury. As a result, over the past year the team have continued to be present within the ED and interact with staff and patients, and have been protected from redeployment to respond to the pandemic. Similarly, the caseworker has continued to have contact with children and young people during the pandemic, and continued to be granted access into the hospital to deliver support. The caseworker provides face-to-face contact to all individuals they support, while the hospital-based VPT has provided face-to-face

support to a quarter of patients attending the ED with injuries (26%, n=123 patients), which was significantly higher among patients with weapon related injuries (56 received face-to-face support; 44% of the cohort).

3.3.3. Staff engagement

Level of engagement

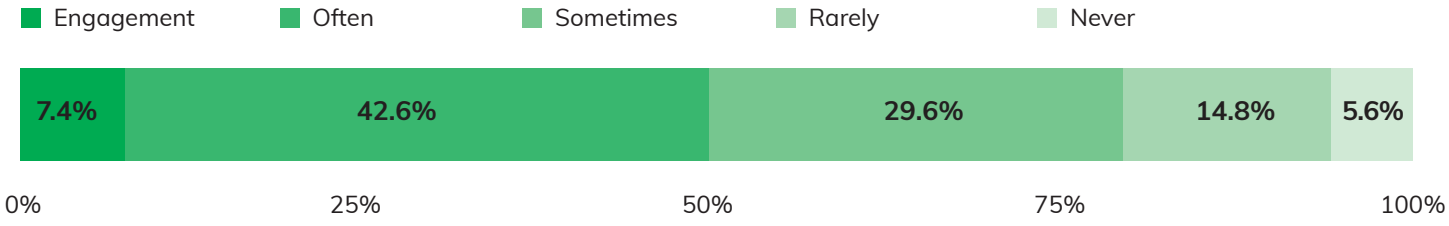
As well as supporting patients, the VPT work within the hospital, and wider healthcare services (e.g. GPs, and minor injury units), to improve knowledge, awareness and practice of the staff interacting with the patients. This team engage with a wide range of staff within the hospital, in both clinical and non-clinical roles, offering support and reassurance to reception staff, health care support workers, nurses, doctors and consultants within the adult and paediatric ED, as well as specialist teams such as the poly trauma unit (e.g. surgical teams and brain trauma service), radiographers, occupational therapists (OTs), physiotherapists (PTs), and post-treatment discharge nurses.

"They engage with the IDVAs, all our staff members really. OTs, yes, the multidisciplinary team really. Primarily medical staff and nursing staff, but obviously the wider multidisciplinary team as well where needed."

Interview 5, Safeguarding team

In the survey, hospital staff were asked how often they engage with the VPT. Of those who completed the survey, 50% stated that they frequently engage with the team (always or often engaged, n=27), while 30% stated that they sometimes engaged with the team (n=16; see figure 4).

Figure 4: *The frequency of engagement participants have with the Violence prevention team*



Type of engagement

Survey respondents were asked what type of engagement they have with the VPT; 13 participants reported that they had never worked with the VPT, although 10 of these participants were aware of colleagues who had. Of those who had engaged with the team, the most frequent type of engagement included making a referral to the team (63% of all participants), consultation on a patient (50% of all participants), and receiving advice, support, and guidance from the team (50% of all participants). In addition, 20% of the participants reported they had received training from the VPT (see table 1).

Table 1: *The type of engagement hospital staff have with the VPT*

Types of engagement	n	%
I have not worked with the violence prevention team	6	11
My colleagues have worked with them but I haven't	10	19
I have received training from them	11	20
I have received advice / support / guidance from them	27	50
I have referred a patient to them	34	63
I have consulted with them on a patient	27	50
I have worked alongside them on the ward	7	13

Training

The VPT provide education and training to staff within the hospital, including training on different forms of violence, the service that the VPT offer, the referral process, and the role of the VPU.

"So we give them a little bit of background on criminal exploitation, sexual exploitation, ACEs which you wouldn't believe - It's not taught, it's really not, still... and especially in the medical world. So we go over ACEs a little and then our basic safeguarding."

Interview 2, Nurse team

Furthermore, the team deliver basic safeguarding training to staff, including training on the referral processes (i.e. multi-agency referral forms [MARFs]), services to signpost patients to, the duty to report violence-related injuries to the relevant services (e.g. police and social services) for all stab-related injuries and gunshot wounds, and any other injuries which raise concerns for the safety of a patient. It was reported that while all patient-facing staff within the Health Board are required to receive a specific level of mandatory training for safeguarding and violence, 100% compliance and adherence rates are almost impossible to achieve. Consequently, there are members of the clinical team who are not fully compliant with safeguarding training. Members of the safeguarding team reported there to be inconsistent, and often low levels of knowledge and awareness on safeguarding within the department, and as such, safeguarding is a vital element of the VPT role. The hospital-based VPT have been provided with formal platforms to deliver training to staff, including a segment in the Health Board level three safeguarding training, which enables them to deliver training to the new doctors on three month rotations.

The team will deliver other forms of training in a 1:1 or group setting, and at times, this can be during their lunch breaks, or since COVID-19, delivered 'on the spot' in the ED or on the wards. Specific training is delivered to certain groups of staff, including reception staff who receive training and input on entering information onto the ED system to improve data quality and consistency. It is reported that delivering training has improved staff engagement with the service.

"What we find is once we've done some education with them the engagement is a lot more positive, a lot more - we do have an open door policy so we make sure that everyone knows where we're located in the department, so they can just pop round and have a conversation which we find once we've done that training with them, they feel more confident to come and find us."

Interview 3, Nurse team

In addition to the training, the team provide feedback and 'positive reinforcement' to staff. The team utilise both formal and informal spaces to provide this feedback, including staff social media platforms (e.g. Facebook) to report on the number of referrals received, to give praise and prompt staff to continue to utilise the service. On the other hand, when referrals are missed or the team identify a concern, the team and clinical leads will engage with the staff, including doctors, to provide feedback, discuss practice, and deliver 1:1 education to encourage them to think about patients and violence prevention differently. Providing feedback and training on the appropriate responses to patients staff have treated is considered a more beneficial approach to learning, allowing staff to reflect on their practice, while also continuing to raise awareness of the service.

"They're very good at positive reinforcements, and they do what I do as well, they'll go and speak to the individual nurse or doctor to say, "Look, this would have been really beneficial for a violence prevention referral," and then they'll do a bit of one-to-one education and training then on the shop floor."

Interview 2, Nurse team

Advice, support and guidance

The team are also available for ad-hoc advice and support, through 1:1 interactions, over the telephone or via email. Much of the interactions between staff and the VPT occur through 'natural exposure', as a result of the team being present within the ED to be at hand to offer support as and when needed. During interviews, it was reported that staff would typically seek advice from the team on how to respond to patients, including what safeguarding may be needed, what to explore with patients, and the services they need to link in with for the patient. The team will work alongside staff to support their engagement with patients, particularly when working with patients who present as agitated and/or aggressive, or adolescents who can be difficult to work with.

"A lot of our 16 and 17-year olds cause a lot of drama in our department, and people forget that they're children. So it's about them observing us then interacting with how we interact with these patients, how we calm them down, how we have conversations with them and how to speak with them just on the basic level of speaking to a 16 and 17-year old because they're not adults, and it's reminding staff of that as well."

Interview 3, Nurse team

"I suppose they're a sounding board as well, so in terms of the education and training, staff may come and just go, "Actually I don't know if this is in your remit, etc," so they're there to provide expert advice really, and then signpost if they're unable to answer those questions."

Interview 5, Safeguarding team

The VPT extend their service beyond the boundaries of the hospital, offering support, training and a referral route into the service to minor injury units (MIU) and General Practitioners (GPs), as well as providing advice and reassurance to community rehabilitation centres, such as the specialist neurological rehabilitation unit. For example, for patients who have suffered brain injury following a violent incident, the team have produced hand-over documents for the service, engaged with them to share relevant information, and in cases where there has been gang violence or organised crime, provide reassurance around the risks.

"There was a lad who was assaulted actually that's going to be transferred to our specialist neuro rehab unit, and it was quite nice having the Violence Prevention Team- They did a nice little report for us just because the consultant was worried about, you know, the perpetrators- What would happen if they knew that he'd moved, it's more of an accessible area where this patient is going to be. So it was quite nice for them to be able to liaise with us and liaise with the police just to kind of clarify that actually, you know, the risk assessments have been done and there isn't anything kind of indicating that there will be any more retaliation and things like that."

Interview 9, Clinical staff

3.3.4. Awareness of VPT

Interview participants reported that there is a good level of awareness of the VPT within the ED, particularly among the nursing staff, consultants and registrars. The ED has a high turnover for all staff, particularly among junior doctors who rotate every three months, which poses a challenge for maintaining an awareness of the service. The interviews demonstrated that the team are very proactive in raising awareness among staff, routinely engaging with new junior doctors and attending the morning handovers with the doctors to provide further input, offer support, and prompt them about the service they offer.

The VPT have worked to advertise their service across the hospital through posters, the NHS intranet page, staff training and by visiting wards. However, it was reported that there is limited awareness of the service within the wider hospital, due to the hospital being so large and with a high rate of staff turnover. It was reflected that 100% awareness would not be realistic, and some felt it unnecessary to have a good awareness of the service across the whole hospital, but rather, it was only necessary for the specialist teams and wards to be aware. These specialist wards were perceived to have a good level of awareness of

the VPT (e.g. poly trauma unit, neuro ward and Maxillofacial ward), and as result, the wards contact the VPT regarding patients, and now know who the team are when they turn up to work with patients.

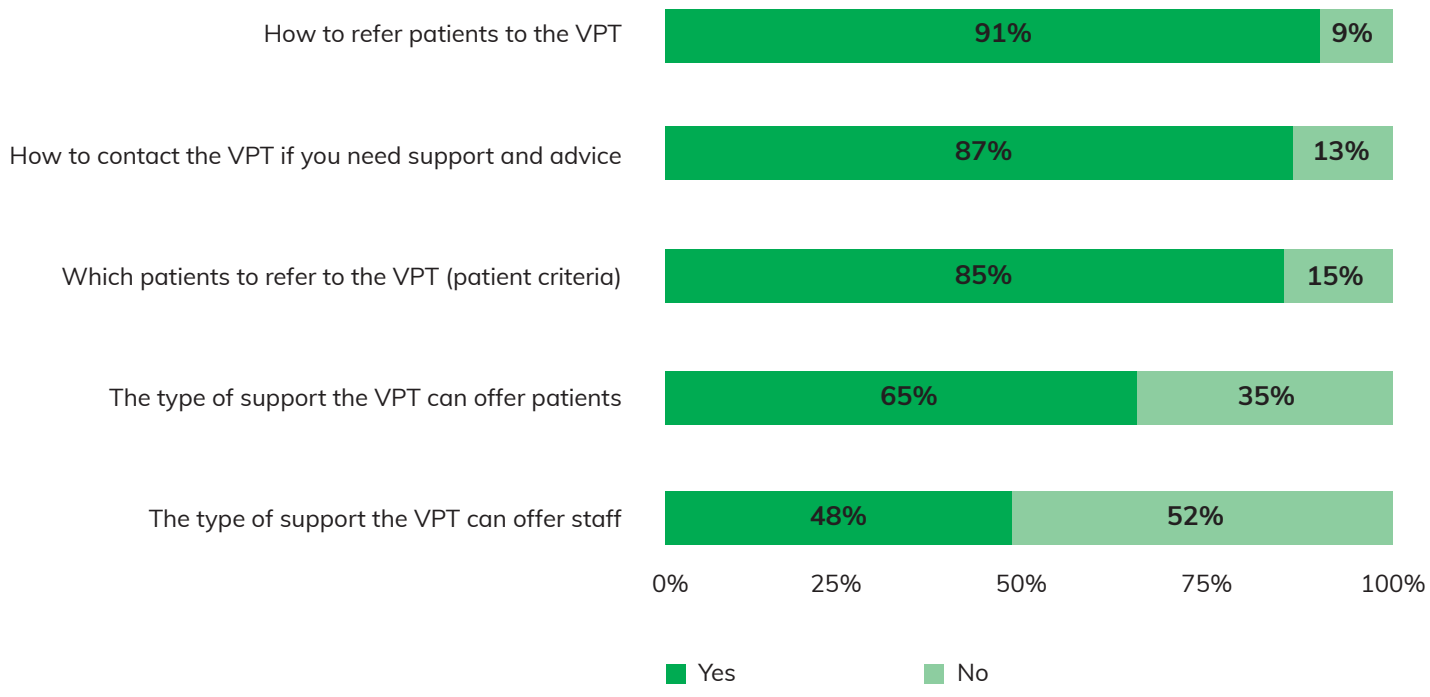
"The consultants always remain and maybe the registrars will but you'll always have a change-over, and when you think about how many teams of medical staff go down to the emergency unit, you know, you've got medical staff, you've got surgical staff, specialists, the dental teams, you know, it's huge."

Interview 4, Safeguarding team

Survey respondents illustrated a high awareness of the VPT within the ED and specialist teams. Participants were asked to rate their level of awareness of the role and responsibilities of the VPT on a five point likert scale (1= not at all aware to 5= extremely aware). Every participant had some level of awareness of the role and responsibilities of the team, with 85% of participants either extremely aware (n=20, 37%) or very aware (n=26; 48%). A small number of participants were only moderately aware (n=4; 7.4%) or slightly aware of the team (n=4; 7.4%).

Participants were asked to state (yes or no) whether they were familiar with the processes of the VPT and the support the team can provide (see figure 5). A large majority of participants stated that they were aware of how to contact the Violence Prevention Team (n= 47), how to make a referral (n=49), and the types of patients to refer (patient criteria; n=46). However, fewer staff were aware of the type of support the team can offer patients (n=35), while less than half of the participants were aware of the type of support the team can offer staff (n=26).

Figure 5: *Hospital staff familiarity with the VPT processes and support provided by the service*



Furthermore, the VPT have also attended various strategic or multidisciplinary meetings, including the corporate bimonthly safeguarding steering group meeting and the medicine clinical board, to provide updates on the service and good practice, publicise it among senior management, and to access resources. However, during the interviews, participants reported that there was a need for the VPT to continue to increase awareness of the service within the wider Health Board. Due to COVID-19, strategic and operational leads have, as expected, focused their attention on managing the pandemic, and as a result the VPT have been offered limited opportunity to promote their service wider.

"We needed to get it [the VPT] back on people's agendas. Not that it's fallen off, but we need to get it, we need to refresh it and put it back out there."

Interview 10, Safeguarding team

3.4. Benefits of a VPT

In the survey, participants were asked to rate how beneficial it is to have a dedicated VPT to respond to, and support, patients with violence-related injury. Participants who had not yet engaged with the team were asked to instead rate how beneficial future engagement with the team would be to their role. Overall, 85% of participants rated the team as highly beneficial (extremely and very beneficial, n=46), 9% of participants rated them moderately beneficial (n=5) and 6% slightly beneficial (n=3)[11]. No participants felt the dedicated team was, or would be, of no benefit.

"The Violence Prevention Team are so welcoming and helpful always! They do such an important job and we are lucky to have them."

Survey, Staff Nurse

Survey respondents and interview participants all provided positive feedback on the VPT, describing them as an "incredibly proactive, passionate team who make a real difference" (Survey, Consultant). The team were viewed as a positive addition to the ED and Health Board, perceiving it to be a "fantastic service, that we probably should have been providing a long time ago" (Survey, Advance Nurse Practitioner). In particular, the VPT were considered very valuable in enhancing the support provided to patients, as well as being a resource for staff to engage with.

"They have helped patients from the moment they have entered the department when referred from triage right through to those of more life threatening violence. They have provided me with warnings if patients are known to them, or have sign posted me when needed. I have seen them interact with patients and their families, often supporting the families as well as the victims. They are an essential service provided by the department."

Survey, Junior Sister

3.4.1. Benefits of the VPT for patients

Increased levels of support in hospital

During the interviews, the participants reported the improvements to patient care for those who attend ED with violence-related injury. Participants working in health reported that, prior to establishing the service, staff within the ED would have only responded to the medical needs of patients, and not the social and welfare needs.

"So some of them may not want any police involvement and we would literally just patch them up, you know, whatever the injury was and then discharge home."

Interview 2, Nursing team

[11] Of those who had engaged with the VPT, 56% rated it extremely beneficial (n=23), 34% very beneficial (n=14) and 10% moderately beneficial (n=4). Of those who had not directly engaged with the VPT, 31% felt the team would be extremely beneficial to their role (n=4), 39% very beneficial, 8% moderately beneficial (n=1) and 23% slightly beneficial (n=3).

For patients who wanted the police to be involved, the staff would support them through the reporting process or liaise with the police on their behalf.

"They would have just taken care of their medical needs where now they're taking care of their welfare and social needs and talking about, you know, things like the trauma that had affected and stuff, and obviously referring them on to an agency that can provide support to them."

Interview 1, Police

Survey respondents also reported that patients are receiving a greater level of support when attending the ED with violence-related injuries. The team have protected time to interact with the patients to provide support and assess safeguarding needs, and as a result, there is "always someone to pick up the slack... patients are never forgotten."

Survey, Nurse

"The team have the ability to spend time with patients that need help. Otherwise they will get overlooked in an emergency department."

Survey, Advance Nurse Practitioner

Participants reported that the VPT hold a wealth of knowledge on violence and how to support victims, as well as the services patients can access. Furthermore, the VPT interact with services, refer into them, and facilitate patient engagement. As a result, patients are engaging with services they previously would not have been aware of or had access to. In addition, the hospital staff reported that the VPT enhance the relationship between patients and health care services, which in-turn can improve patient outcomes (e.g. re-attendance/ readmission).

"They've got a lot of sort of referral to other agencies within their arsenal, so they've got links with lots of other outside agencies and support mechanisms. So they're really key with those patients, and I think a lot of the teenage patients, they really benefit from them."

Interview 5, Safeguarding team

Increasing the support available to patients who present to the ED with violence-related injury was considered highly important to participants, who reported that these patients often have a level of vulnerability. Service data further demonstrated this: within the period of a year, 37% of patients who attended the ED with violence-related injury reported that they had a known mental health condition (n=175 patients), 26% suffered with substance abuse (n=124), 24% were intoxicated at the time of their ED visit or injury (n=116), 10% experienced domestic violence (n=49 patients) and 6% were homeless (n=29; see Appendix 3 table 6). Additionally, there is a high level of frequent attendance to the ED from patients with violence-related injury, with the number of visits ranging from 0-128 times (over a ten year period), with 30% of patients attending the ED 1-5 times, 21% attending 6-10 times, and 24% of patients attending the ED more than 10 times.

Only 28% of patients who attended the ED with violence-related injuries self-reported that they were already receiving support from another service (n=132 of 477 patients), although, for patients with weapon-related injuries, only 16% were open to another service (n=20, of 126 patients). Following attendance to the ED, 44% of all patients with violence-related injury were referred on to another agency (n=208 patients), including 57 of the patients attending with weapon related injuries (see Appendix 3 table 7 for a further breakdown in agencies referred to and support provided). Furthermore, during the interviews the VPT reported reductions in re-attendance rates following engagement with the service, particularly among those with knife-related injuries.

"There was 100 patients that came through the door for knife related attendances [Nov 19- Jan 21] and the ones that didn't engage had a 25% re-attendance rate for either mental health, another violence related attendance or drug and alcohol [within the review period]. The ones that we did engage with only had a 3%, so we were really, really happy, ecstatic when that came out really, and then just some of the positive outcomes we had with our patients in regards to them getting re-housed, not coming back the department is a massive one for us because we get a lot of frequent attenders."

Interview 3, Nurse team

Enhanced safeguarding responses

Survey respondents and interview participants reported the improvements the VPT have made to safeguarding practice within the hospital. Prior to the establishment of the VPT, the practice was for hospital staff to submit a MARF to safeguard patients who presented as a risk to themselves, children or the public. However, often safeguarding would be missed, particularly for patients presenting with significant trauma and requiring life-saving treatment.

"If they presented a risk to children or themselves or the public then it would depend what I would do with regards to safeguarding and reporting. I wouldn't have reported all knife related injuries prior to this as an A&E sister, only the ones of significant risk would we really report. That has changed now."

Interview 2, Nurse team

Since the team has been established, there has been a significant improvement in safeguarding practice within the ED. Participants report improved understanding and consideration of safeguarding among staff and better identification of patients with safeguarding concerns or in need of additional support. As a result, there has been an increase in the number of MARFs which have been submitted by staff, as well as a high number of MARFs submitted by the VPT. Service data demonstrated that within the period of a year, MARFs were submitted for 24% of all patients attending ED with violence-related injury (n=115 patients).

"I feel this is a vital role and team within the emergency unit. If we did not have this team safeguarding opportunities would be missed due to high volume of patients to staff ratio [...] Overall I feel without this team in situ we would be failing the community."

Survey, Nurse

In particular, there has been improvements in the reporting of violent incidents to the police. The VPT have promoted the 'duty to report' policy to all staff, and as a result, all stab-related injuries have since been reported to the police. In addition, the VPT has increased the number of patients who report violent incidents to the police and who provide statements to support safeguarding investigations.

"It is very important to have a service that encourages reporting of incidents with violence involved. Knowing that patients are followed up and may engage more than with the police."

Survey, ED Nurse

"Say our knife related injuries would come into resus, there's a trauma call and they had life threatening injuries, that would be all I'd be focused on as an A&E nurse. It would just be about saving their lives and very often safeguarding isn't considered because you're so in the zone of saving their life. So since this role I now look at the bigger picture [...] safeguarding is equally as important to saving their lives, and it's something that they really need to try and drill in to consider after it all- Even if it's done a day later, it's just vitally important that we consider it and it certainly wasn't something that I would have considered prior to this role."

Interview 2, Nurse team

Furthermore, the VPT have increased the safeguarding for victims of domestic abuse who attend the ED; the team have engaged with staff to enhance 'Ask and Act' practices, ensuring staff ask every patient a standardised set of questions to assess experience of domestic abuse, regardless of the reasons for attending the ED. As a result, the ED has had a substantial increase in domestic abuse disclosures, with data highlighting a three-fold increase in disclosures January 2021 (n=32 referrals) compared to January 2020 (n=11 referrals). The VPT and safeguarding team reported that the increase in disclosures has been facilitated by the COVID-19 restrictions on hospital visitation, with patients required to attend the ED alone rather than accompanied.

"All the A&E staff have done thousands of Ask and Acts on thousands of patients and increased our disclosures by 130% I think we worked it out as. Like we have nagged and nagged and nagged those staff to do that work, they've worked extra hard doing it, you know, it's additional work for them to do and it takes a lot of training to teach people to feel comfortable enough to ask about domestic abuse."

Interview 2, Nurse team

Improved data quality

The VPT reported the challenges they have experienced with the data obtained from the hospital on attendance for violence-related injury; the Health Boards in South Wales utilise the Cardiff Model for data sharing, which has established a system to standardise data collection within the hospital (referred to as Information Sharing to Tackle Violence [ISTV] in England). Reception staff collect and enter information on the system regarding the patient, their injury (e.g. type and mechanism of injury) and about the violent incident (e.g. date, location and perpetrator). However, during interviews the VPT and hospital staff reported that this system is susceptible to human error due to the complexity of data entry, and the frequency in which reception staff change within the hospital. As a result, there are large gaps in the dataset, providing an inaccurate representation of the volume of violence-related injuries attending ED, and a larger gap in the number of violence-related injuries known to the police.

"Our major problems with that stabbing data is because any significant injury comes into the hospital as a major trauma, so a major trauma could be a car crash or a stabbing. So I'd say over 50% of our stabbings weren't being listed as stabbings because they were being booked in as major trauma."

Interview 2, Nurse team

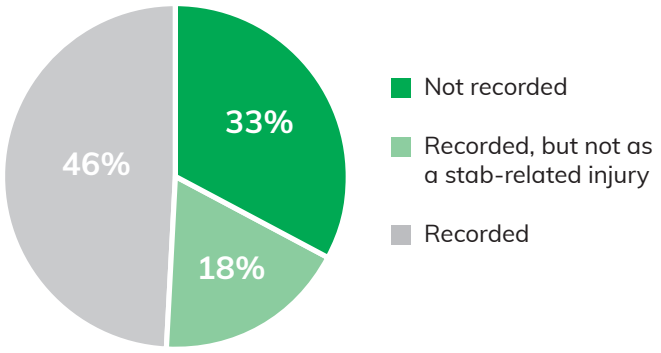
Through staff training, the VPT have been able to close the gap in the volume of patients attending the ED and what is captured within the standardised dataset. What's more, the VPT have established their own dataset to routinely monitor any disparity in data, and have worked alongside the VPU to inform them of the errors in the data and how to improve the dataset.

"We identified that there's a gap between the datasets, what the emergency department have collected and what the Violence Prevention Team are coming across on a monthly, quarterly basis. So that's already started the conversation around those individual cases that might have slipped through the net."

Interview 1, Police

A review of the dataset provided by the VPT demonstrates significant discrepancies between the actual volume of patients who have attended the ED with stab-related injuries, and the number of patients captured within the Cardiff Model standardised dataset. Specifically, during the period of a year (July 20- June 21) only 49% of stab injuries were accurately recorded within the standard dataset, while 18% were miscoded as another form of injury. Furthermore 33% of the patients with stab-related injuries were not recorded within the ED standard dataset (see figure 6).

Figure 6: *Number of stab related injuries recorded by the VPT captured within the Cardiff Model dataset (July 2020 - June 2021)*



Participants reported that data improvements are on-going and, with efforts to extend the standardised data across Wales, is currently being viewed from a national perspective. Furthermore, it was reported that in order to maintain current improvements, frequent staff training is required, and further refinement of the existing data collection system in place.

"I feel that there should be more of a fool proof setup so that we're not just relying on human input, because staff change all the time. So...that means that you have to continue educating admin staff, whereas if the system was easier no matter who worked it, it would have the right input."

Interview 2, Nurse team

Consistent and more reliable datasets provide the VPU and respective organisations (e.g. Police and Public Health Wales) a more informed picture of the nature and scale of violence, and the hotspots, which can better inform operational and strategic responses to reduce and prevent violence.

Identifying individuals unknown to services

During interviews, the participants reported the benefit of the VPT in identifying victims of violence who are not known to services. In particular, the caseworkers have raised that a number of the children on their case load, who were referred through the hospital-based team, have not been known or had any involvement with statutory services, including police, child protection services and youth justice services. These children, referred to by the caseworkers as 'ghost children', include those who are involved in serious violence, including exploitation and other related crimes, which services are unaware of. The caseworker reflected that this is down to 'changing tactics' of these serious organised crime groups and perpetrators; typically these groups would exploit children who are very vulnerable and well known to services (e.g. children in foster care). It was noted that more recently they have been identifying children with fewer vulnerabilities who are not monitored by services. The caseworker suggested that professionals (e.g. education) and parents may struggle to identify these children due to limited understanding of exploitation.

"I think that times are changing a little bit where I think maybe exploiters know that it's quite hard actually to go in on those kind of young people because there's so many people watching them. So I think now there is, it's starting to happen more where we're seeing more young people that maybe are doing well in school or could be from good communities but nobody is watching them. So it ends up being that they're the ones that probably get caught up in these situations where there's been no services involved."

Interview 11, Caseworker

Additionally, the caseworker is able to identify and respond to hidden harms within the community due to the close connection to professionals (e.g. social workers), young people and their families, who pass the information on to the caseworker with the knowledge that they work for the VPU. For example, a stabbing in Cardiff had been reported to the caseworker; following discussions with the hospital-based VPT and police, it became apparent that the victim had not reported this or presented to the ED or other healthcare service for medical intervention.

"That's happened a couple of times where I've heard on the streets something's happened, I phone the hospital and they're like, we've got no record of anyone, and so they've stayed on the streets."

Interview 12, Caseworker

3.4.2. Staff knowledge, awareness and confidence

Knowledge and awareness

Survey respondents reported that the VPT have improved their knowledge and awareness of violence and how to respond to patients. Improvements have been made through training, but also through the day-to-day interactions with the team.

"Staff are on hand to answer questions and will explain referrals and how they deal with patients. Will engage and share knowledge."

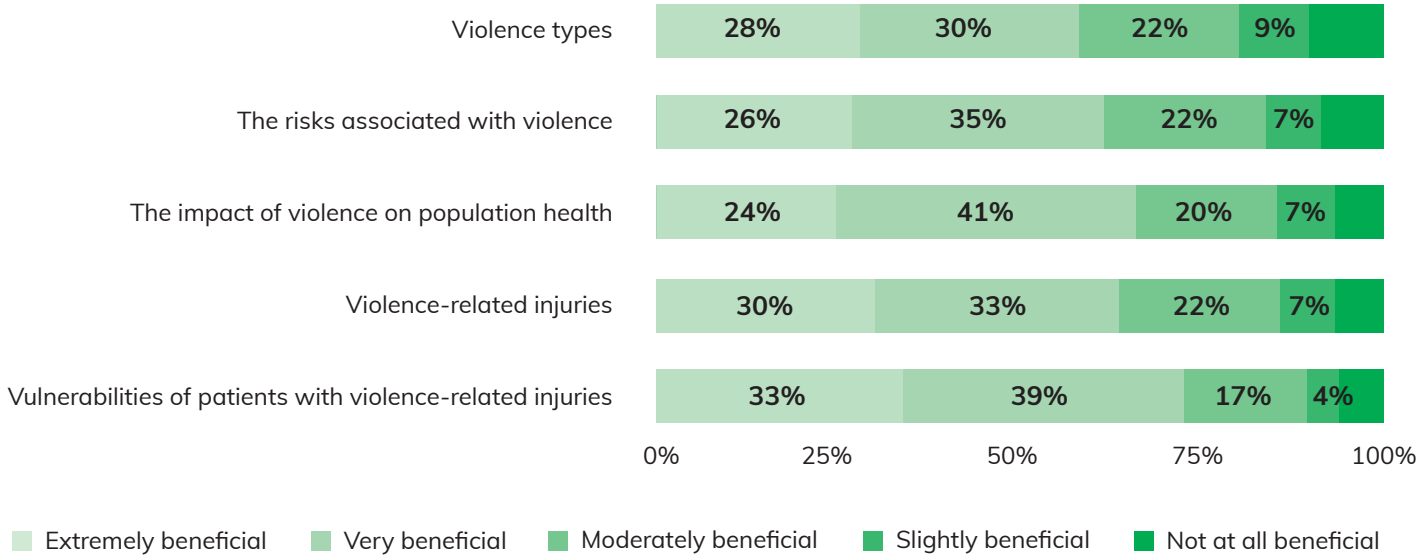
Survey, Senior Staff Nurse

"[The VPT] highlight the need for intervention, vulnerabilities of clients, improves staff knowledge on services available and service/intervention available, support for staff."

Survey, Safeguarding Nurse Advisor

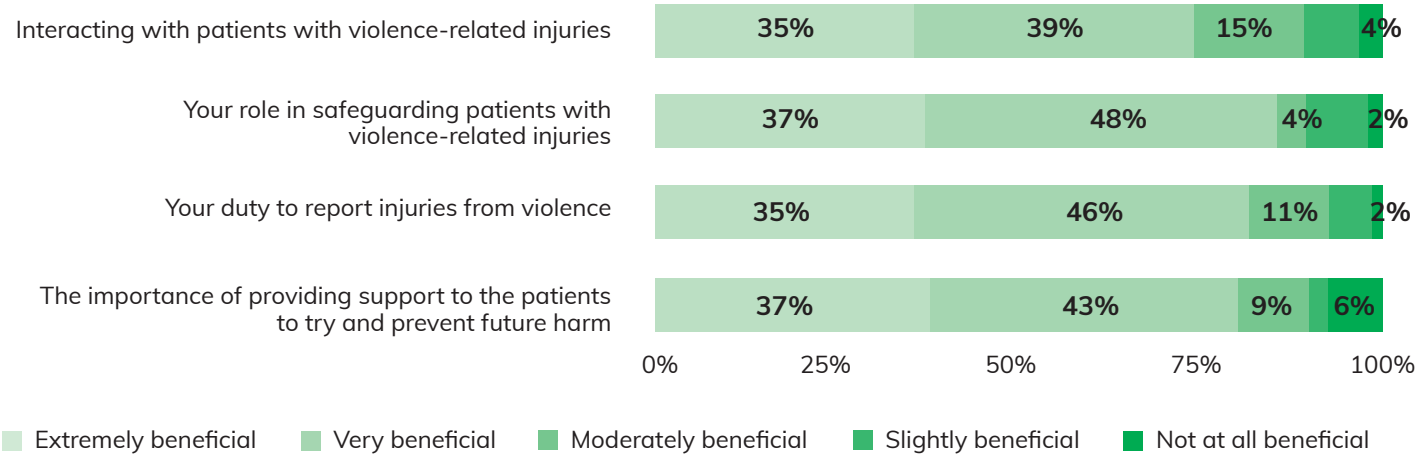
Survey respondents were asked to rate on a 5-point likert scale how beneficial the VPT had been in enhancing their knowledge and awareness of violence, and responses to violence (1= not at all beneficial, to 5= extremely beneficial). Over half the participants rated the VPT as highly (extremely or very) beneficial in enhancing the knowledge and awareness of: violence types (58% of participants), the risks associated with violence (61%), the impact of violence on population health (65%), violence-related injuries (63%) and the vulnerabilities of patients with violence-related injuries (72%; see Figure 7).

Figure 7: *Participants rating of the extent to which the VPT have benefited staff knowledge and awareness of violence*



Participants reported the VPT to have been particularly beneficial in enhancing their knowledge and awarness on how to respond to patients with violence-related injury; the majority of participants rated the team as highly (extremely or very) beneficial in enhancing their knowledge and awareness of their role in safeguaring patients (85% of participants), their duty to report injuries (81%), the importance of providing support to prevent future injury (80%), and how to interact with patients (74%; see figure 8).

Figure 8: *Participants rating of the extent to which the VPT have benefited staff knowledge and awareness of how to respond to patients*



Confidence working with patients with violence-related injury

Staff confidence was explored in the survey (see table 2 for confidence levels). A large proportion of respondents reported a high level of confidence (rated extremely or very confident) in how to respond to patients presenting with violence-related injury, including: identifying injuries which have resulted from violence (60%), their understanding of reporting responsibilities, procedures and processes (64.5%), reporting injuries to the police (62.2%) and making a referral to safeguarding services (75.6%). However, less than half the sample felt highly confident engaging with intimate partners (40%), discerning the cause of injuries (37.8%), attaining an accurate account of how injuries occurred (46.7%), providing advice and support to patients (44.5%), and accurately coding and recording injuries (35.5.%). This demonstrates that staff are not confident in their interactions with patients and their families, and more work is needed to further enhance this confidence. However, staff are confident in how they are expected to respond to patients with violence-related injury, and feel confident to report and refer patients for the injuries they present with.

Table 2: *Hospital staff self-reported confidence levels responding to patients with violence-related injuries*

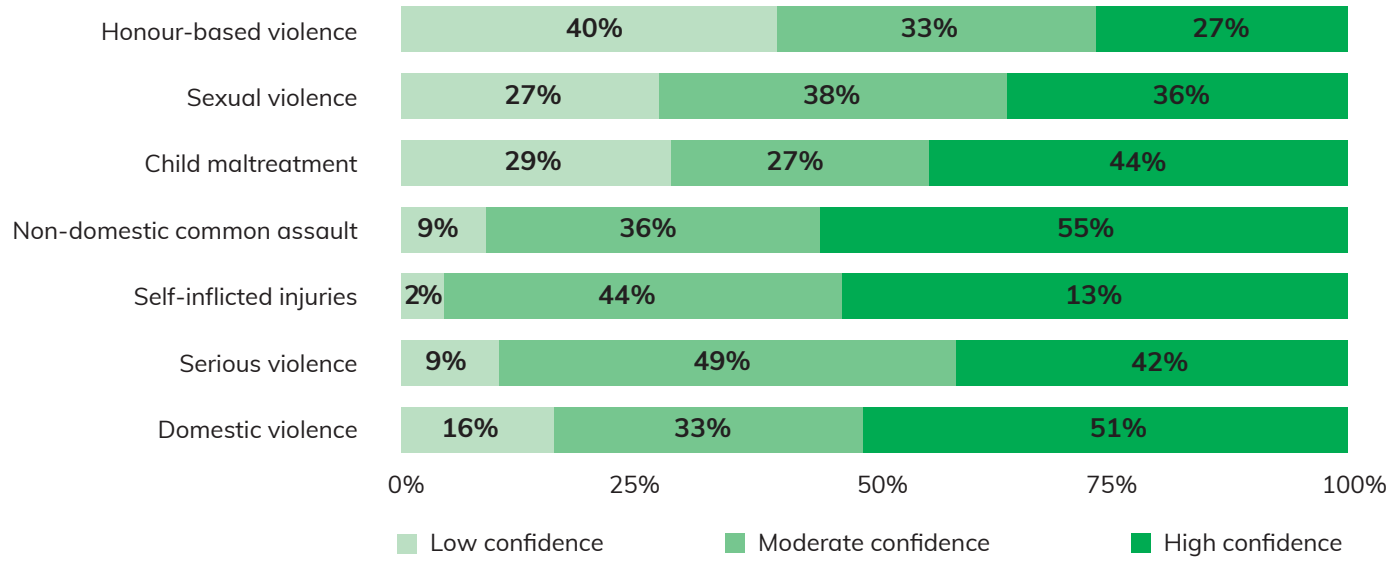
N=45	Low confidence	Moderate confidence	High confidence
Identifying injuries which have resulted from violence	4.4%	35.6%	60%
Discerning the causes of injuries	8.8%	53.3%	37.8%
Engaging / connecting with the patients	2.2%	44.4%	53.4%
Attaining an accurate account of how the injuries occurred	6.6%	46.7%	46.7%
Dealing with family / friends	11.1%	31.1%	57.8%
Dealing with intimate partners	17.8%	42.2%	40.0%
Providing advice and support to the patients	17.8%	37.8%	44.5%
Your understanding of reporting responsibilities, procedures and processes	8.8%	26.7%	64.5%
Reporting injuries to the police	11.1%	26.7%	62.2%
Making a referral to safeguarding services	6.6%	17.8%	75.6%
Accurately coding and recording the violence injuries	33.3%	31.1%	35.5%

In the open responses, many respondents reported on the challenges they experience engaging patients, and obtaining accurate information on the causes of injuries. More specifically, respondents reported that patients are often reluctant to disclose to professionals, particularly patients who are fearful of the repercussions from the perpetrator(s) (e.g. intimate partners or gang members). As a result, patients can be 'evasive', or are distrusting of professionals. Furthermore, participants reported that 'time' can be a barrier, with staff unable to build a rapport, counsel patients and encourage them to engage with services. Supporting patients who are intoxicated or mentally unwell was also reported to be challenging for staff.

"Depends on each patient some are very open, some try and lie about their injuries but usually the injury doesn't correspond with the mechanism. Some patients are drunk or on drugs and make it difficult initially."
Survey, Emergency Nurse Practitioner

Furthermore, participants were asked to rate how confident they felt dealing with and/or treating patients presenting injuries from different forms of violence. Participants were particularly confident responding to patients injured through non-domestic common assault (55.5% high confidence), self-inflicted injuries (53.3%) and domestic violence (51.1%). However, participants were less confident responding to serious violence (42.2% high confidence), children maltreatment (44.4%) and sexual violence (35.6%), while only a quarter of the participants felt highly confident responding to honour based violence (see Figure 9).

Figue 9: *Participants confidence to respond to patients attending ED by forms of violence*



In the survey, participants were asked whether there were any particular population groups they find challenging to engage with and support. Respondents reported challenges in supporting patients from minority groups, including the travelling community (n=3 respondents), ethnic minorities (n=5 respondents), and patients whose first language is not English (n= 2 respondents). Participants also reported challenges supporting adolescents (n=5 respondents), and young adults aged 18-30 years (n=2). One male member of staff also reported that they find it challenging to support women who attend the ED following sexual assault.

In the survey, participants were asked to note any additional support, guidance, training and/or resources needed to enhance interactions with patients in relation to dealing with injuries as a result of any form of violence. Participants reported more training would be beneficial, with suggestions including simulation training, information on the services available to keep patients safe, how to deal with abusive partners when they attend with patients, training on safeguarding referrals and:

"Identification [of patients], specific injury management and reporting/accessing support for families."

Survey, Doctor

"A complete study day on the role of the team. The types of violence. How to report and code them. Follow up. Support for patients and staff."

Survey, Health Care Support Worker

Other suggestions included updates relating to gang violence, posters and leaflets to disseminate to patients on the service and for support, and written guideline on how to access/refer to the VPT.

"I feel maybe more advice leaflets need to be available to help continue to sign post people giving them the opportunity to disclose information independently to support networks. I feel a study day needs to be developed for nursing and medical staff to attend to highlight the importance of identifying vulnerability and how patients might present to the unit and what support is available to them in the community."

Survey, Nurse

3.5. Challenges and areas for further development

During the interviews, participants highlighted a small number of gaps, or areas for further development for the service to consider.

3.5.1. Capacity and resourcing

Participants suggested there is a need to increase the capacity and availability of the VPT. It was viewed that with just two members of staff operating within the hospital, there was little resilience in the service, and as a result, if staff needed to take time off (e.g. annual leave) there would be a significant impact on the service delivery. Furthermore, clinical staff raised concerns that the level of violence would increase as COVID-19 lockdown restrictions ease. It was also reported that the hospital became a MTC during the COVID-19 period, and as a result, it was expected that the volume of demand would increase, particularly among services such as the brain injury service. An increase in demand has been observed since April 2021, with the VPT reporting referrals for 277 patients from the ED, children's hospital and MIU (April- June 2021; see table 3). This is a 432% increase in demand compared to the same period the previous year, whereby the service received referrals for 52 patients during the first quarter of 2020-21 financial year.

In addition, participants raised that the VPT work week days, and felt it would be beneficial to patients if the service extended their hours to be available at night time and/or on the weekends. Currently, patients who attend the hospital on the weekend are referred to the VPT, or the team will pick the patients up from the ED record management system, and the team will follow up with support. Participants reported that increasing the service operating times would enable patients to receive support when they attend the ED, rather than waiting a day or two, and subsequently increase engagement.

Table 3: *Referrals received by the VPT for violence-related injury April-June 2021*

April – June 2021	24 and under	25 and above	Total
Knife / sharp object related injuries / gun shot wound	8	15	23
Assault	90	74	164
Self-inflicted punch injuries	24	12	36
Other	3	1	4

"They do follow-up things on patients that come in at night but clearly they're not there at night and if someone's admitted then that's fairly easy but if somebody's discharged it's much harder to follow that up in the community."

Interview 8, Clinical staff

The VPT typically work Monday to Friday, between the hours of 7.00-17.00, which were viewed as standard hours for safeguarding. Safeguarding leads reported that in establishing the VPT, they were willing to work more flexible hours, however, the team still receive the referrals from staff to allow them to engage with patients that attend the ED on the weekend, thus, felt there was no need for the service to operate on the weekend.

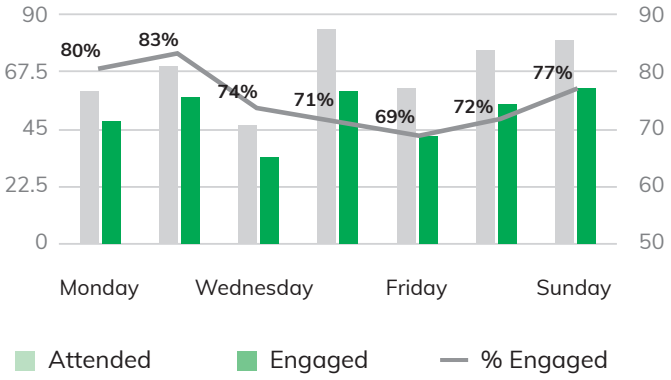
"We haven't felt the need for those working to expand onto the weekend or to working evenings because the referrals flow anyway. You know, there would be flexibility if there needed to be, but it's just not felt to be required."

Interview 4, Safeguarding team

Service demand data demonstrated that over the period of a year, the ED received the highest volume of patients on Thursday (18% of attendances), followed by Sunday (17%) and Saturday (16%), with the lowest attendances on Wednesday's (10%) and Monday's (13%; see Appendix 3, graph 3). A review of the data during August and September, when the night-time economy had opened back up, demonstrated no significant difference in ED attendances on the weekend (see Appendix 3, graph 4).

The data demonstrates that engagement with the VPT is higher following attendance to the ED on Monday and Tuesday (80% and 83% respectively). However, there are no discernible differences in the level of engagement following attendance to the ED on Saturday and Sunday, when the VPT are not on shift (see graph 1).

Graph 1: *Level of patient engagement with the service by days of the week patients attended the ED (April 20- March 21)*



Participants reported that the hours would need to be reviewed as COVID-19 lockdown restrictions ease, but recognised the challenges of delivering weekend services. However, the onsite police reported that, to fill in the service gap over the weekend and at night, the team could up-skill the police officers and staff (e.g. Police Community Support Officers) who work on-site at the hospital, and to allow them to pick up tasks for the VPT (e.g. engage with patients, gather intelligence, signpost to services).

"A challenge there, is providing or continuing to provide a service for them right the way through the night, especially at the weekend. And that's challenging in terms of costs to the NHS."

Interview 7, Clinical staff

"So if something came in over the weekend, so to say, if we had that better understanding and knowledge would we maybe be able to start the ball rolling before they come in on a Monday morning and try and put other little bits and bobs in place and help out, and that I think would increase our knowledge, their benefit and workload but also give that person an earlier start as to where they're signposting so to speak maybe."

Interview 6, Police

The caseworkers reported that being part of the Action for Children Side-Step programme offers resilience to the delivery of their service, with other caseworkers available to cover cases if the hospital caseworker required time away from work. However, the caseworker reported challenges with their capacity to pick up referrals. With just one caseworker assigned to the hospital, and a restricted case load (of 5 individuals), the caseworker has very limited availability. This would be particularly problematic if there was another major incident resulting in multiple referrals, which the caseworker felt was a possibility given the level of risk and volatility of groups of individuals within the local area at present. The caseworker reported that they are able to draw on other services to pick up cases, but recognise these services to also be working at capacity.

"Being the only youth worker linked to the VPU, sometimes that's a challenge because if you've got a caseload- So I've got a caseload now, if anything kicks off, like it's been kicking off in Cardiff and we have a load of – please God, don't let it happen, like mass stabbings and they need to come to us- Like in my head I'm thinking, how would I deal with picking up all those young people."

Interview 12, Caseworker

3.5.2. Working with partner agencies

The participants gave examples of gaps in the services and support available outside of the VPT. In particular, participants reported a need for better access to support and intervention for mental health and emotional well-being, particularly for those who have experienced significant trauma in the past, or as a result of the violent incident they attended the ED for.

"There's a massive gap for mental health interventions, massive. There's just nowhere to get people in, CAMHS waiting list is ridiculous."

Interview 12, Caseworker

Furthermore, the caseworker expressed interest in enhancing how they work with criminal justice agencies. While the Side-Step programme work to divert children and young people away from further involvement in serious violence and organised crime, often these individuals have a history of criminality, and as a result, they may be under investigation or pending arrest. As a result, there has been cases where individuals have engaged with the caseworker and taken positive steps towards rehabilitation, but have later become incarcerated preventing the continuation of support. The caseworker suggested that as part of the VPT , they need to link up with prisons to work with children who have been involved in serious violence and have been exploited, to continue the work within the prison or maintain engagement to ensure that "when they come out they're not going back to square one. The groundwork's already there, things are in place for when they come out of prison."

Interview 12, Caseworker

Information sharing between organisations

The VPT reported that information sharing was a challenge for both the hospital-based team and the caseworker. The team reported that, at times, services are unwilling to share information with them on a child or their family, which is essential for risk assessments and in determining what support to provide.

"So, challenges that I can face as well are when other services are open but not willing to share information or they are open and they've been open for six months but they haven't actually- The files are empty, they've done nothing. So then you're going in and that young person's like, "Well I haven't seen my such and such worker for six months," like so that barrier's already up and that trust is already tough to build up."

Interview 12, Caseworker

On the other hand, the VPT experience challenges sharing information with others without formal agreements in place. For example, probation share information with the VPT, but without an information sharing agreement the team are unable to share information with probation which makes them appear obstructive or difficult to work with. The VPT felt that better information sharing will improve relationships between organisation, and ultimately, patient outcomes.

The caseworker reported further challenges with information sharing; specifically, how information the caseworker shares with police is used. As previously mentioned, the caseworker becomes privy to a lot of local intelligence from the children and families they work with, social workers and other professionals (e.g. the locations of missing children, incidents of serious violence that have not presented to the ED or known to the police). The caseworker will share this information with the relevant agencies, namely the police, however, at times this information has been shared with the individuals who have been reported. The caseworker stated that this can put them at risk, as well as any children and families the caseworker initially received the information from.

"Information has been fed to us, we've fed it to the police and then they've gone back and said this information has come from like your youth workers and obviously you're trying to protect the family that it's come from, so then you're taking the hit. Whereas really they can filter that out and they don't need to say that it's come from us."

Interview 12, Caseworker

Working with children unknown to services

Furthermore, the caseworkers reported that working with children and families who have not previously engaged with services can be challenging, with the information available limited to what the hospital-based VPT collate during initial assessment. The wider Side-Step programme typically only work with children who are supported by statutory services, to ensure the child is safeguarded when working to divert them away from serious violence. The caseworkers stated that, unless the child discloses involvement in drug and/or gang activity, it can be challenging to evidence the underlying risks necessary to put safeguarding arrangements in place through child protective services.

Furthermore, the caseworkers reported that with no prior involvement with services, parents are reluctant to engage with the service due to fear of the repercussions:

"I think the stumbling blocks probably are that it could be fearful amongst family who have never had services involved that if you've got the social worker involved or a probation worker involved, how is your family going to be looked upon? Are they a bad family and stuff, and I think sometimes it's more the fear factor of what's going to go with that rather than the support they're going to get. So I think again it's about how everyone sells the service that they're going to give to the individuals or the family."

Interview 11, Caseworker

3.6. Future service delivery

3.6.1. Service sustainability

All participants felt that the VPT was an effective service, which is necessary within the hospital based on the current demand for the service and the valuable role the service plays in safeguarding patients with violence-related injury. Furthermore, over the course of the pandemic, the hospital became a MTC, receiving injuries from out of area, subsequently, demand is expected to continue to rise as the COVID-19 restrictions ease.

"We are having a large amount of assaults and stab injury - knife crime, so yes, I think it definitely is sustainable [...] and I can't now imagine a world without them, from my perspective in terms of safeguarding as well, because it does close the loop."

Interview 5, Safeguarding team

However, it was felt that in order for the service to be sustained, it needs to continue to operate in its current mode of delivery, with the dedicated nurse team based within the ED to work alongside staff, continue to train them, ensure referrals are being submitted and that data entry continues to improve and become more consistent.

"I think if we disappeared tomorrow but the service still existed through say a referral process instead of somebody physically being there, I feel like it would fall away if it was left to the medical team."

Interview 2, Nurse team

Furthermore, the health professionals stated that the service needs to continue to be co-delivered with the police through the VPU or PCC office, and to take a multi-agency approach with key partners (e.g. local authorities). The VPU offer substantial benefits for the service providers, enabling access to a range of information and resources which would otherwise not be available, delivering local problem solving and supporting the providers to overcome barriers (e.g. housing), and convening multi-agency meetings to coordinate responses to major incidents. Furthermore, the involvement of the VPU allow the service to maintain its strategic priorities within the hospital; it was felt that, without police engagement, the priorities of the service may change to operate under the 'health agenda' rather than a joint one.

"The best way it can be sustained is through a joint partnership with ourselves and police. You know, safeguarding, we pride ourselves on safeguarding being the most effective safeguarding infrastructure is one of multi professional, multiagency approach."

Interview 10, Safeguarding team

The VPT is funded by the Home Office, through the VPU budget, and currently operates on short-term (annual) funding. All participants reflected that the sustainability of the service is dependent on continued funding provisions. It was felt that the VPU could work towards achieving joint funding from health and police, working with the PCC office and safeguarding leads to establish a business case. However, in order to achieve a business case, participants reported the importance of evaluation to evidence the service is cost-effective and achieving its desired outcomes.

"I think we would have a good reason for keeping it but I think if the funding wasn't there it would be difficult because you'd be battling against many other priorities within the Health Board then."

Interview 4, Safeguarding team

"So one of the conditions for the roll out, if this is proved to be successful, is that actually... the knowledge that it works is disseminated and it affects Welsh Government Investment and Health Board Investment and police force investment in keeping it going."

Interview 7, Clinical staff

3.6.2. Wider roll-out of the service

Participants viewed the service as one which has the potential to be rolled out to other hospitals in Wales, and wider. The model is considered a simple one that would be easy to replicate provided it has the people in place with the drive to deliver it.

"I think it's an easy model to try and roll out in another area. It's not been difficult, I think what you need is motivated and forward-thinking staff who are prepared to put the work in to embed the service really."

Interview 4, Safeguarding team

While the demand on health care services for violence-related injury can vary by area, participants reflected that all areas experience violence and would therefore benefit from a specialist service. The VPT report that this has become apparent when engaging with colleagues that have left the hospital, with medical staff now working in different health boards still approaching the team to request support with patients, or to be directed to appropriate resources. To develop and deliver the service in other hospitals, there is a need to assess the scale and type of demand, to determine the level of resourcing needed against costing. It has been suggested, for example, that a 'hybrid model' could be utilised, producing a dual role to respond to patients presenting with injuries which are linked to both serious violence and domestic abuse. As a result, budgets could be pooled to reduce the costs. This will also produce the opportunity to have discussions with Welsh Government about the health budget and the available funding to support the roll out of the service.

"We will take each area on its own kind of merits and use the data to kind of shape what the model will look like in each area."

Interview 1, Police

An ED within Swansea is viewed as the next hospital for consideration, situated within the second largest city in Wales (after Cardiff), and subsequently with the second largest volume of violence with injury. It is reported that within Swansea, there are a number of approaches and interventions being delivered which would complement a hospital-based violence prevention service:

"We're already working more closely with partners there around serious youth violence and, you know, taking a contextual safeguarding approach down there. But they're bringing more and more partners together and only in the last few weeks they've been talking to us about more young people going through custody and more young people ending up in ED with wounding's and injuries through serious violence. So, naturally I think Swansea would be the next best place for us to trial it."

Interview 1, Police

Hospitals in other health board areas have demonstrated an interest in establishing a hospital-based service (i.e. Dyfed Powys), and as a result, have engaged with the VPT to seek their advice and guidance.

Section

4

Discussion

4.0. Discussion

In England and Wales levels of violence have been on the rise over the past five years, particularly youth violence (e.g. knife crime)(9). The Home Office has funded the network of Violence Reduction Units to take a public health, multi-agency approach to violence, and to deliver early intervention and prevention, therapeutic support and diversionary programmes, which are place-based and informed by evidence.

Many VRUs have invested funding in hospital-based violence prevention programmes, which operate within EDs to divert children and young people away from violence at what is considered a 'teachable moment'. These models place youth workers or advocates within the hospital to make contact with patients attending the ED with injuries resulting from serious violence, to divert them away from further involvement in violence. Evaluations of hospital-based violence prevention programmes within the UK show promising outcomes, although this evidence is limited in scope (15–17). However, there has been numerous evaluations of similar models delivered in hospitals in the United States, including randomised control trials. These evaluations have demonstrated reductions in hospital re-admissions, arrests and convictions for violent crime, and time spent incarcerated, while also providing support that the programmes could produce substantial cost savings for health care and criminal justice systems (18–20).

Collaboratively, the Wales VPU and safeguarding service within the Cardiff and Vale University Health Board, developed and implemented the VPT to work in the University Hospital of Wales. A nurse-led model was established, comprising of a nurse and an advocate operating within the ED, and a caseworker providing support to patients within the community. The service aims to improve the identification of patients with injuries caused by violence, increase the reporting of violent-related injuries to the police and provide support to address patient vulnerabilities and risk factors for violence victimisation and perpetration. This evaluation has demonstrated the role of the VPT in providing support and addressing the needs of patients with violence-related injury. Furthermore, it has provided an assessment of the delivery and implementation of the service, and highlighted areas for further development, and considerations for the sustainability and wider roll-out of the service to other health settings in Wales.

Understanding the role of the VPT in supporting victims of violence-related injury

The findings report that in Wales, the VPT offer a unique model which has been developed to meet local demand, and the needs of the population the hospital serves. The service seeks to engage with all patients presenting with non-domestic violence-related injuries, to offer support and address patient vulnerabilities at the earliest opportunity. Early intervention and prevention within the hospital was considered essential in reducing the risk of patients becoming involved in more serious and harmful forms of violence.

This evaluation highlighted that patients presenting to the ED with violence-related injury can have a wide-range of vulnerabilities, such as poor mental health and substance misuse, but often these individuals are not open to other services. The risk- and needs- based assessments that the VPT have developed allow the team to better identify these vulnerabilities to inform the patient care plans. These assessments also allow the team to put measures in place to reduce the risks of further harm to individuals within the hospital and community, particularly for patients involved in serious organised crime, drug and/or gang related activity.

Following assessment the VPT provide support, or access to services, to address multiple needs; this includes mental health and emotional support, family relationships, housing, substance misuse, education and employment and criminality. Additionally, the caseworker provide children and young people access to a range of interventions to enhance interpersonal skills, provide education, promote a more positive future and facilitate movement away from involvement in youth violence.

To enable the hospital-based VPT to provide a more universal service for all patients presenting to the ED with violence-related injuries, the team work in tandem with the hospital IDVA service, and utilises wider health care- and community based- services that can work with the patient to address the vulnerabilities and risk factors for involvement in violence. Furthermore, the VPT has a community-based caseworker to provide longer-term and more intensive support to children and young involved in serious organised crime, drug related activity and exploitation. The team has established an efficient process for identifying and responding to patients; this includes the referral process which offers flexibility and ease to staff within the ED, while also providing a safety net to ensure all patients with violence-related injuries are identified and offered support.

The level of support the VPT provide patients can vary largely based on the severity of the patient's injuries, their level of vulnerability, risks and unmet needs, and their willingness to engage with the service. However, with the exception of the caseworker, the VPT typically interact with patients for a relatively short period of time, while maintaining a very small caseload of longer-term patients. This allows the team to maintain the capacity to work with a higher number of patients.

The effectiveness of the implementation and delivery of the VPT

Participants reported that the ED is an exceptionally challenging environment to work in due to the busy and fast paced nature of the department. However, the VPT have successfully integrated the service into the hospital and clinical processes, and as a result, the team are highly valued and considered beneficial to the staff working within the ED and specialist teams. Positioning a nurse and an advocate within the hospital-based team has provided considerable benefit for both staff and patients; the team has clinical knowledge which facilitates their interactions with the medical team and allows them to understand the patients' medical needs. Furthermore, through the advocate, the team is aware of a wide range of different services to signpost or refer patients to, and understand the criminal justice and social care processes. This experience has enabled the VPT to provide a more extensive range of support to patients, to overcome any barriers to patient and staff engagement, and to extend the service wider within the Health Board.

To successfully embed the service in the hospital, the VPT have spent a considerable amount of time upskilling staff to enhance their knowledge and awareness of violence, to raise awareness of the service, and improve safeguarding practice. Frequent engagement and training with staff is important to ensure they utilise the VPT and report injuries to the police, while also improving the interactions the staff have with patients. Staff in the hospital reported frequent engagement with the VPT, and a high level of awareness of the service and processes for patients with violence-related injury. Furthermore, the staff report that the team has enhanced their knowledge and awareness of violence, including violence types, the risks associated with violence, the impact it has on population health, violence-related injuries and the vulnerabilities of these patients.

Additionally, the team has enhanced the staff awareness of, and confidence in how to interact with patients with violence-related injury, their role in safeguarding patients, the duty to report injuries to the police, and the importance of providing support to patients to prevent future harm.

As a result, the service is identifying and engaging with patients, particularly children and young people, who are not known to services. Safeguarding practices have also significantly improved within the ED, with an increase in the referrals forms submitted for patients, and in the number of disclosures of domestic abuse through the increase in 'Ask and Act'. The VPT have also improved the quality and consistency of hospital data to provide a more accurate representation of the nature and scale of violence, which is integral in enabling a public health approach to violence prevention. Furthermore the team provide the VPU with data to enable inaccuracies to be identified within the standardised system, to inform the further development of violence surveillance in Wales on a local and national level through the Violence Intelligence for Prevention (VIP) Hub.

However, maintaining staff knowledge and improved practice has proven challenging within the ED and wider hospital due to the frequency of staff turn-around, particularly among doctors, and as such, staff training and engagement needs to remain a key element of the role of the VPT. That said, it is expected that on-going training will provide considerable benefit in the long-term, with staff transferring this knowledge and practice to other health care settings within the Health Board, and wider.

Furthermore, the VPT have been successful in engaging patients with the service and in accessing support. The VPT are viewed as part of the medical team rather than a third party or external professionals, which enables them to overcome barriers for many of the patients. As a result, the service has a 75% engagement rate with all patients attending the ED with violence-related injury, which include patients who typically would not engage with services.

Challenges and areas for further development

While the service has been successfully embedded into the ED, a small number of challenges and areas for development have been identified. In particular, clinical staff raised concerns that the service is not operating during peak time, and that time off work for the team poses a risk to service delivery. Therefore, there is a need to increase the staffing team to improve the capacity and resilience of the service, and consider extending or altering their hours to meet the demand. This is particularly since the hospital has been established as a major trauma centre taking injuries from additional localities, and as the COVID-19 restrictions ease. In addition, the caseworker has limited capacity to pick up referrals from the hospital, which raises concerns for their ability to respond to any major incidents.

Furthermore, the service reported challenges in accessing mental health and well-being support for patients. Patients attending the ED with violence-related injury can experience significant trauma which can further enhance their vulnerability to violence victimisation and perpetration (21). As such, a service is needed to address the mental health of patients in a timely manner to enable them to progress towards rehabilitation. In addition, there is need to improve cross-sector working, particularly with criminal justice agencies, to ensure continuity of support and consistency in approach.

The sustainability and wider roll-out of the service

Service providers, clinical staff and partners felt the service could be rolled out to wider hospitals in Wales, and one which would be easy to replicate in other areas of Wales due to the simplicity of the model developed. However, the service is reliant on funding from the Home Office (through the Wales VPU), which currently offers short-term, annual funding. To ensure sustainability, longer-term funding provisions needs to be secured, which could pool funding across different sectors (e.g. health and policing).

To secure funding to continue to deliver the service and roll it out wider, the VPT needs to be able to demonstrate that the service provides a cost benefit, and evidence the impact it is having on reducing violence and re-injury. The current evaluation has demonstrated that the VPT has enhanced the support provided to patients with violence-related injury, as well as safeguarding practice, and as a result patients are receiving holistic support that can address the wider needs and vulnerabilities that are known to increase the risk of involvement in violence. Research has demonstrated that addressing patient needs and risk-factors are integral in preventing further violence; risk factors for involvement in violence include low socio-economic and education status, unemployment, unstable family structure and childhood trauma, substance abuse, poor mental health, and previous violence victimisation (5,22,23). The VPT have demonstrated their success in providing access to support to address the risk factors, and patients willingness to engage with these services. However, the evaluation does not assess the impact of the service on patients outcomes (e.g. re-injury and violence perpetration), or assess the benefits of the service against the costs of running it. Therefore, further evaluation is needed to continue to develop the evidence-base for the service.

Conclusion

Patients attending ED with violence-related injury can often have multiple, complex needs and vulnerabilities that increase the risk of further involvement in violence, either as a victims and/or perpetrator. The VPT offers a service to identify patients with violence-related injury, and to provide access to support to address their needs and divert them away from violence. The service has been successfully embedded into the hospital, and has established an effective model for responding to patients. The service has begun to demonstrate positive outcomes, including improved safeguarding, greater access to support for patients, and improvements to staff knowledge, awareness and confidence responding to patients with violence-related injuries. However, further work is needed to understand the impact of the service on patients, and the cost-benefit of the service to obtain longer-term funding.

Recommendations

Based on the evaluation findings presented, it is recommended that:

- The VPT continue to engage criminal justice agencies, including police, prison, probation and the youth justice service, to identify further opportunities to enhance collaboration in supporting individuals involved in violence.
- The NHS identify and secure a longer-term commitment of funding for the VPT, and explore opportunities to continue to develop the service within the Health Board.
- The VPT continue to operate as a collaboration between police and health, to ensure the service maintains a focus on violence prevention and vulnerability.
- The VPT consider their operating times, by monitoring and assessing the volume of patients attending the ED, and patient engagement with the service on evenings and weekends.
- The service explore opportunities to increase the capacity of the community-based caseworker to enable them to offer the intensive, longer-term support to a higher number of children and young people at high risk, who are presenting to the ED.
- The service and strategic leads further identify or establish mental health and well-being support for individuals who have experienced trauma, and who are involved in serious organised crime, drug related activity, and have been exploited.
- The VPT strategic leads commission further evaluation of the VPT, including an impact and economic evaluation, exploring the impact of the service on violence victimisation and perpetration (e.g. re-injury, re-attendance and arrest rates).
- The VPT explore opportunities to deliver further training to staff within the hospital, to enhance their knowledge and awareness of violence, and confidence to respond to patients.
- The VPU and VPT work together to fully understand the challenges with the existing standardised data collection system, and consider opportunities to further improve data collection.

References

1. Home Office. Serious Violence Strategy. London; 2018.

2. Brice JM, Boyle AA. Are ED-based violence intervention programmes effective in reducing revictimisation and perpetration in victims of violence? A systematic review. Emerg Med J. 2019;37(8).

3. Mercy JA, Hillis SD, Butchart A, Bellis MA, Ward CL, Fang X, et al. Interpersonal Violence: Global Impact and Paths to Prevention. In: Mock CN, Nugent R, Kobusingye O, Smith KR, editors. Injury Prevention and Environmental Health [Internet]. 3rd ed. Washington DC: The International Bank for Reconstruction and Development / The World Bank; 2017. Available from: https://www.ncbi.nlm.nih.gov/books/NBK525218/

4. Hoeffler A. What are the costs of violence? Polit Philos Econ [Internet]. 2017;16(4):422–45. Available from: https://ora.ox.ac.uk/objects/uuid:22d9fce1-0c39-48ca-9023 da8f121cf380/download_file?file_format=pdf&safe_filename=AHCost%2Bof%2BViolence17.pdf&type_of_work=Journal+article

5. Sethi D, Hughes K, Bellis MA, Mitis F, Racioppi F. European Report on Preventing Violence and Knife Crime among Young People [Internet]. WHO Regional Office for Europe, Copenhagen; 2010. Available from: http://www.euro.who.int/__data/assets/pdf_file/0012/121314/E94277.pdf

6. World Health Organization. Preventing youth violence: an overview of the evidence [Internet]. Luxembourg; 2015. Available from: https://apps.who.int/iris/bitstream/handle/10665/181008/9789241509251_eng.pdf;jsessionid=5DAF26D43461BD68081CC8DED2FBE6B1?sequence=1

7. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health [Internet]. Geneva; 2002. Available from: https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=5E42C38E4C2C9DB8FF84F59DB2546772?sequence=1

8. Office for National Statistics. Crime in England and Wales: Appendix tables [Internet]. 2020 [cited 2021 Apr 22]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/crimeinenglandandwalesappendixtables

9. Office for National Statistics. Dataset: Offences involving the use of weapons: data tables [Internet]. 2020 [cited 2021 Apr 22]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/offencesinvolvingtheuseofweaponsdatatables

10. Office for National Statistics. The nature of violent crime in England and Wales: year ending March 2020 [Internet]. 2020 [cited 2021 Apr 22]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/thenatureofviolentcrimeinenglandandwales/yearendingmarch2020

11. Office for National Statistics. Dataset: Appendix tables: homicide in England and Wales [Internet]. 2020 [cited 2021 Apr 22]. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/appendixtableshomicideinenglandandwales

12. Sivarajasingam V, Guan B, Page N, Peel E, Moore S, Shepherd J. Violence in England and Wales in 2019: An Accident and Emergency Perspective [Internet]. Cardiff; 2020. Available from: https://www.cardiff.ac.uk/__data/assets/pdf_file/0009/2288520/Violence-in-England-and-Wales-2019_NVSN-Annual-Report.pdf

13. Jones L, Bigland C, Quigg Z. Cost of violence to the healthcare system in Wales [Internet]. 2020. Available from: https://www.violencepreventionwales.co.uk/cms-assets/research/Costs-of-violence-to-the-healthcare-system-in-Wales.pdf#:~:text=Violence imposes a large economic burden on the,associated with addressing the consequences of interpersonal violence.

14. Gray B, Barton E, Davies A, Long S, Roderick J, Bellis M. A shared data approach more accurately represents the rates and patterns of violence with injury assaults. J Epidemiol Community Heal. 2017;71(12):1218–24.

15. Associates N. Youth Violence Intervention Project: St Mary's Hospital. 2018.

16. Ilan-Clarke Y, Kagan L, & JD, Bifulco A. Evaluation of Oasis Youth Support violence intervention at St. Thomas' hospital in London, UK [Internet]. Middlesex; 2016. Available from: http://www.oasiswaterloo.org/wp-content/uploads/2019/11/Final-report-15-Nov-2016_Evaluation-of-St-Thomas-OYS-intervention-1.pdf

17. Goodall C, Jameson J, Lowe DJ. Navigator: A Tale of Two Cities [Internet]. 2020. Available from: http://www.svru.co.uk/wp-content/uploads/2020/02/Navigator-12-month-report-2_0.pdf

18 Cooper C, Eslinger DM, Stolley PD. Hospital-Based Violence Intervention Programs Work. J Trauma Inj Infect Crit Care. 2006;61(3):534–40.

19. Purtle J, Rich JA, Fein JA, James T, Corbin TJ. Hospital-Based Violence Prevention: Progress and Opportunities. Am Coll Physicians. 2015;163(9).

20. Juillard C, Cooperman L, Allen I, Pirracchio R, Henderson T, Marquez R, et al. A decade of hospital-based violence intervention Benefits and shortcomings. ournal Trauma Acute Care Surg. 2016;81(6):1156–61.

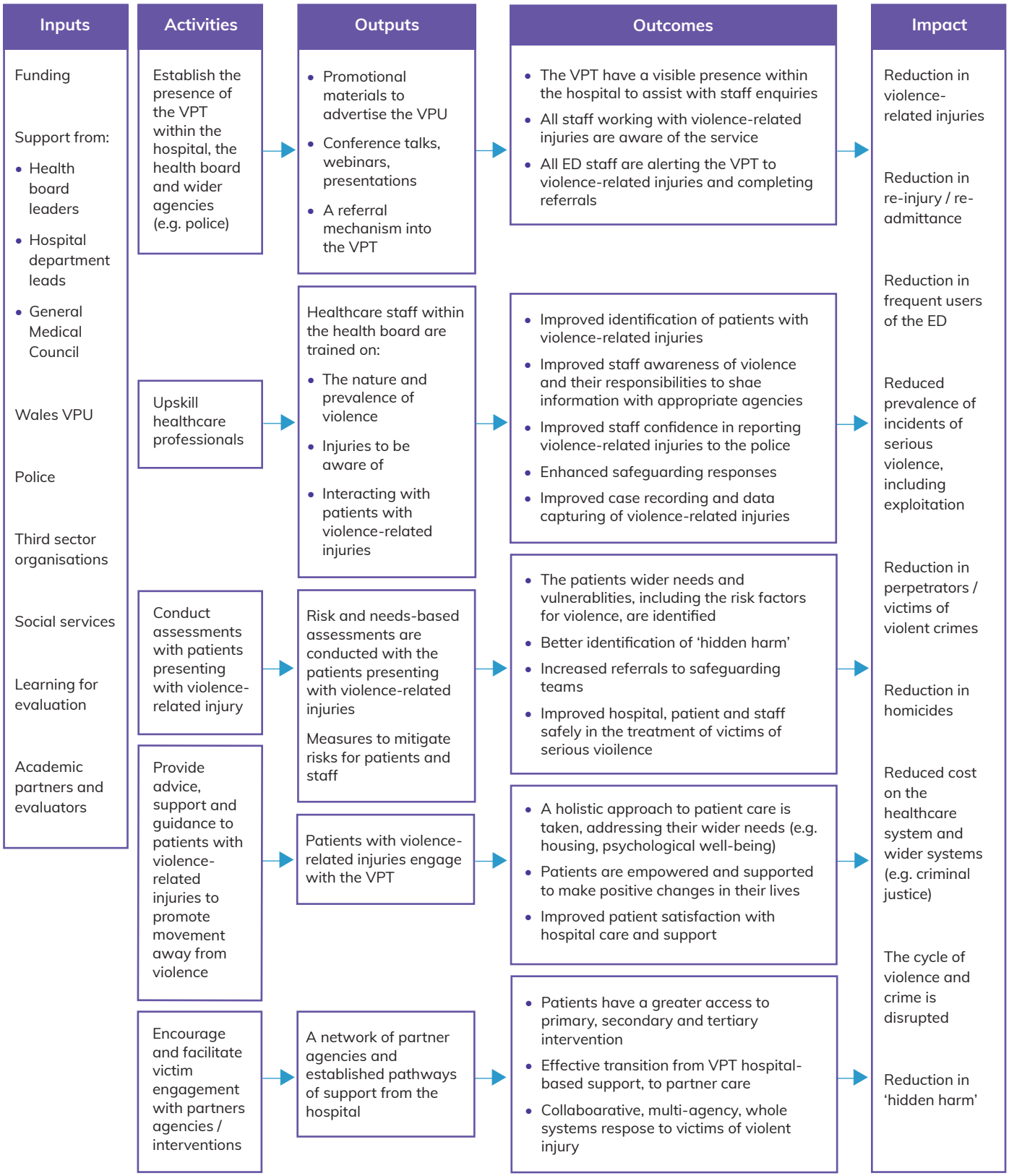
21. Corbin TJ, Purtle J, Rich L, Rich J, Adams E, Yee G BS. The prevalence of trauma and childhood adversity in an urban, hospital-based violence intervention program. J Health Care Poor Underserved. 2013;24(3):1021–30.

22. Smith V, Wynne-McHardy E. An analysis of indicators of serious violence Findings from the Millennium Cohort Study and the Environmental Risk (E-Risk) Longitudinal Twin Study [Internet]. 2019. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/819840/analysis-of-indicators-of-serious-violence-horr110.pdf

23. Newbury A, Snowdon LC, Barton ER, Atter B, Parry B. Serious Youth Violence in South Wales: Strategic Needs Assessment. Cardiff; 2020.

Appendix 1

Appendix 1: Theory of Change for the VPT



Appendix 2

Appendix 2: Data tables from the online survey

Table 4: *Demographic characteristics of survey respondents*

Demographic		n	%
Total participants		54	100
Age	18 - 24 years	2	4
	25 - 34 years	24	44
	35 - 44 years	14	26
	45 - 54 years	5	9
	55 - 64 years	8	15
	65+ years	1	2
Gender	Man	13	24
	Woman	40	74
	Non-binary / self-described	1	2
Ethnicity	White	52	96
	Asian / Asian-British	1	2
	Mixed	1	2
Range of duration working in a hospital setting	0 - 37 years		
Duration working in a hospital setting	0 - 5 years	15	28
	6 - 12 years	14	26
	13 - 17 years	14	26
	18+ years	11	20
Department	ED	43	80
	Safeguarding	9	16
	Major trauma	2	4
Job role	Nurse / Nurse practitioner	31	57
	Doctor / consultant	10	19
	HCSW / HCA	7	13
	Other	6	11

Table 5: *Survey respondents confidence to identify and respond to patients with violence-related injuries within the hospital.*

	Level of confidence (n=45)									
	Not at all		Slightly		Moderately		Very		Extremely	
	n	%	n	%	n	%	n	%	n	%
Identifying injuries which have resulted from violence	2	4.4	0	0.0	16	35.6	22	51.1	5	8.9
Discerning the causes of injuries	2	4.4	2	4.4	24	53.3	14	31.1	3	6.7
Engaging / connecting with the patients	0	0.0	1	2.2	20	44.4	16	35.6	8	7.8
Attaining an accurate account of how the injuries occurred	1	2.2	2	4.4	21	46.7	17	37.8	4	8.9
Dealing with family / friends	1	2.2	4	8.9	14	31.1	19	42.2	7	15.6
Dealing with intimate partners	1	2.2	7	15.6	19	42.2	13	28.9	5	11.1
Providing advice and support to the patients	1	2.2	7	15.6	17	37.8	16	35.6	4	8.9
Your understanding of reporting responsibilities, procedures and processes	2	4.4	2	4.4	12	26.7	21	46.7	8	17.8
Reporting injuries to the police	4	8.9	1	2.2	12	26.7	17	37.8	11	24.4
Making a referral to safeguarding services	2	4.4	1	2.2	8	17.8	17	37.8	17	37.8
Accurately coding and recording the violence injuries	5	11.1	10	22.2	14	31.1	11	4.4	5	11.1

Table 6: *Survey respondents confidence to respond to victim of different forms of violence within the hospital.*

Participant rated confidence in responding to different types of violence (n=45)										
	Not at all confident		Slightly confident		Moderately confident		Very confident		Extremely confident	
	n	%	n	%	n	%	n	%	n	%
Domestic violence	1	2.2	6	13.3	15	33.3	14	31.1	9	20
Serious Violence	2	3.7	2	3.7	22	40.7	15	27.8	4	7.4
Self-inflicted injuries	0	0	1	1.9	20	37	18	33.3	6	11.1
Non-domestic common assault	1	1.9	3	5.6	16	29.6	20	37	5	9.3
Child maltreatment	2	3.7	11	20.4	12	22.2	10	18.5	10	18.5
Sexual violence	4	7.4	8	14.8	17	31.5	9	16.7	7	13
Honour-based violence	8	14.8	10	18.5	15	27.8	7	13	5	9.3

Appendix 3

Appendix 3: An overview of findings from the service-level data

Hospital-based VPT

Service demand

In total, 477 patients presented to the ED with violence-related injuries within the period of a year (April 2020-March 2021), of which, there were 126 stab-related injuries. The data collated by the VPT highlight that the age of individuals attending the ED for violence-related injuries ranged from 9 years to 86 years, with 44% of ED assault attendances under the age of 25 years (n=199), 20% of which for children under the age of 18 years. There was a higher attendance to ED for individuals aged 25-34 years, accounting for 27% of attendances for violence-related injury, and 34% of attendances for stab related injuries. Furthermore, 80% of ED attendances for violence-related injuries were male (89% of attendances for stab-related injuries were male).

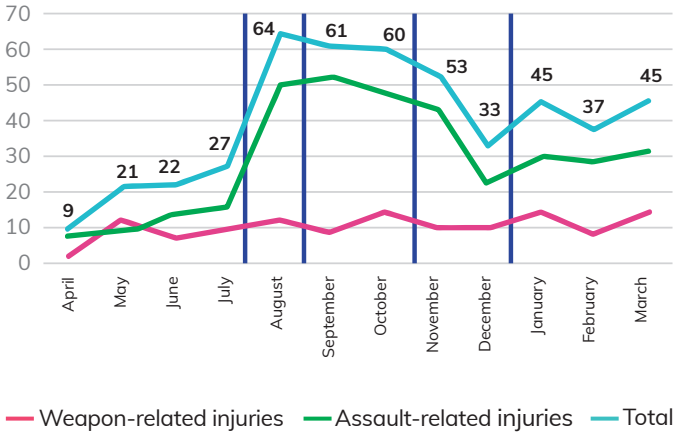
Table 7: *Survey respondents confidence to respond to victim of different forms of violence within the hospital.Demographics of patents attending the ED with violence-related injury April 2020- March 2021*

	Violence-related injury				Weapon-related injuries (n=126)			
	Female	Male	Total		Female	Male	Total	
			n	%			n	%
<18 years	17	77	94	20	0	10	10	8
18 - 24 years	20	85	105	22	1	31	31	25
25 - 34 years	27	103	130	27	5	38	43	34
35 - 44 years	13	52	65	14	4	17	21	17
45 - 54 years	13	40	53	11	4	11	15	12
55 - 64 years	0	21	21	4	0	5	5	4
65+	1	8	9	2	0	0	0	0
Total	**91**	**386**	**477**	**100**	**14**	**112**	**126**	**100**

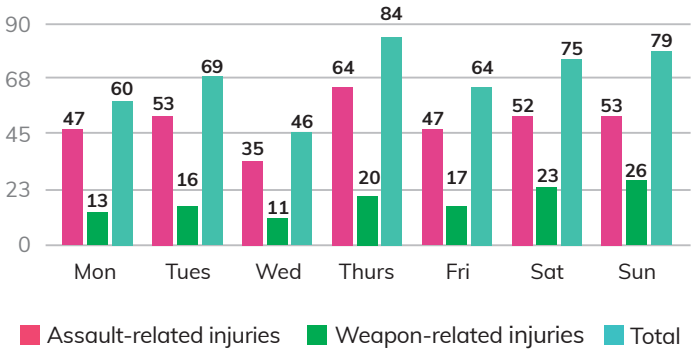
Due to COVID-19, over the period of the year the UK and Welsh Government enforced Health Protection measures (from March 2020). This included considerable social restrictions, with people urged to stay at home, as well as changes to the accessibility of health care services (e.g. GP appointments delivered virtually, and people required to call before attending the ED). Attendance to ED for violence-related injury has been affected by the social restrictions in place.

The data demonstrates exceptionally low attendance to the UHW ED for violence-related injury during the month of April (n=9), however these numbers gradually rose, particularly as Wales began its phased reopening of hospitality and tourism mid-July (pubs and restaurants opened July 13th 2020). The number of individuals attending the ED has since fluctuated from month to month (see graph 2).

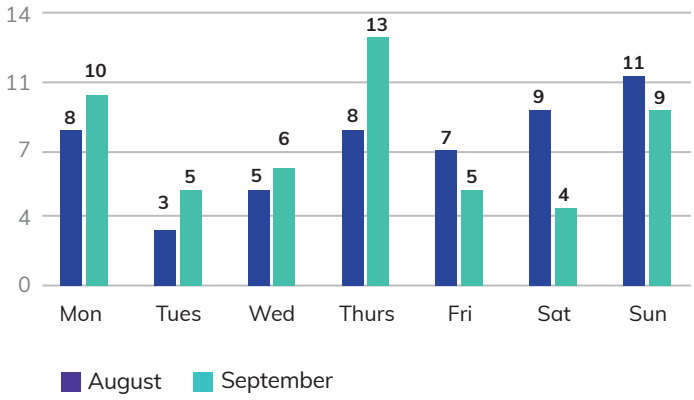
Graph 2: *ED attendance for violence-related injury April 20-March 21*



Graph 3: *ED attendance for violence-related injury by day of the week (April 2020-March 2021)*



Graph 4: *Attendance to the ED for violence-related injury Aug - Sept 2020)*



Furthermore, the data demonstrates that, on average over the period of the year, the ED receives the highest volume of patients on Thursday (18%), followed by Sunday (17%) and Saturday (16%). During a two month period where the NTE was open, attendance to the ED for violence-related injury was slightly higher on Saturday and Sunday during the month of August, however, during September, the trend was consistent with the annual daily average.

Patient vulnerabilities

The patients attending ED with violence-related injury present with a wide range of vulnerabilities, which can include ACEs, learning disabilities and developmental disorders, domestic abuse and mental health. Table 8 highlights the key vulnerabilities recorded: 28% of patients were open to another service, including a small number of patients supported by statutory services; 7% of patients had a social worker at the time of their ED attendance (7%), including 12 Looked After Children (LAC), 10% were on probation, and 1% were supported by youth justice services. Over a third of patients had a diagnosed mental health condition (37%), which was particularly high among patients who had been injured by a weapon (42%).

Furthermore, a quarter of patients experienced substance misuse, 10% were either a victim or perpetrator of domestic violence, and 6% were homeless.

The hospital-based VPT reviewed the patient's health records to identify the frequency of attendance to ED for each patient. This has highlighted a high level of previous attendance to the ED for patients, with an average of 8 previous visits to the A&E within the Cardiff and Vale Health Board area (ranging from 0-182 previous visits). Notably, a quarter of patients had visited the ED more than 10 times, while only 17% of patients reported the attendance to be their first visit.

Table 8: *The vulnerabilities of patients attending the ED with violence-related injury*

Vulnerabilities	Assault-related injuries (n=351)		Weapon-related injuries (n=126)		All violence-related injuries (n=477)	
	n	%	n	%	n	%
Open to another service	112	32	20	16	132	28
Social services:						
• Social worker involved	27	8	5	4	32	7
• Looked after child	9	3	3	2	12	3
Offender management:						
• National Probation service	28	8	20	16	48	10
• Youth Offending Service	2	1	1	1	3	1
Intoxicated during ED attendance	81	23	35	28	116	24
Mental health	122	35	53	42	175	37
Substance misuse	82	23	42	33	124	26
Domestic violence	31	9	18	14	49	10
Homelessness / housing	19	5	10	8	29	6
Number of previous visits to the ED	**Average 9 visits Range 0-128**		**Average= 7 visits Range 0-46**		**Average= 8 visits Range 0-128**	
0	50	14	29	23	79	17
1 -5	107	30	34	27	141	30
6 - 10	73	21	25	20	98	21
11 -20	53	15	27	21	80	17
21 -30	18	5	3	2	21	4
30+	11	3	1	1	12	3
Missing data	38	11	7	6	45	9

Data is missing for patients who are from out of area. Cardiff and Vale do not have access to patient notes from other health board areas.

Support provided by the hospital-based VPT

In total, 344 patients with violence-related injuries were referred to the hospital-based VPT (72%), including 97% of patients attending the ED with weapon-related injuries, and 63% of patients with other assault-related injuries. Of those who attended the ED with violence-related injuries, 75% engaged with the VPT for support (66% of patients with weapon related injuries engaged).

Furthermore, the VPT provided face-to-face contact to over a quarter of all patients (26%, n=123), including almost half of the patients presenting to the ED with weapon-related injuries, and maintained longer-term contact to 15% of patients.

The VPT signposted and referred patients to a wide range of services, including 115 multi-agency referrals forms were submitted to local authorities by the VPT and ED staff (24% of patients). The most common service patients were referred to include victim support services (44% of patients), domestic abuse services (24%) and Action for Children Side-Step programme (6%).

The VPT support patients to report their injuries to the police, to share intelligence, and to give a statement to the police. In total, 60% of patients had reported their injury to the police, 30% provided a statement and 4% allowed intelligence to be submitted. However, 100% of incidents had been reported to the police where patients attended the ED with knife-related injuries.

Table 9: *The support the hospital-based VPT provided patients with violence-related injury*

Support provided to patient	Assault-related injuries (n=351)		Weapon-related injuries (n=126)		All violence-related injuries (n=477)	
	n	%	n	%	n	%
Referred to the VPT	222	63	122	97	344	72
Engaged with VPT for support	275	78	83	66	358	75
Admitted into hospital	113	32	45	36	158	75
Received face-to-face contact	67	19	56	44	123	26
VPT provided longer-term support	48	14	22	177	70	15
MARF completed	70	20	45	36	115	24
School Nurse/Health Visitor notified	30	9	4	3	34	7
Referred on to other agencies:	**151**	**43**	**57**	**45**	**208**	**44**
• Victim support	89	25	24	19	113	24
• Domestic abuse services	7	2	5	4	12	3
• Sexual violence services	7	2	0	-	7	1
• Housing support	7	2	2	2	9	2
• Action For Children	11	3	17	13	28	6
• General Practitioner (GP)	6	17	0	-	6	1
• Drug and alcohol services	5	1	7	6	12	3
• Mental and emotional well-being	9	3	0	-	9	2
Criminal justice actions						
• Reported to the police	200	57	88	70	288	60
• Patient statement given	118	34	31	25	149	31
• Intelligence submitted by VPT	6	2	11	9	17	4

Community-based caseworker demand and support

In total, 40 patients has been referred to the Side-Step programme, of which, they service has worked with 17 individuals. With the exception of one individual, all children and young people engaged with the caseworker.

Furthermore, the data demonstrates a high level of vulnerability in the children and young people supported, with the majority of individuals living in deprivation, and identified as 'Not in Education, Employment or Training' (NEET). Furthermore, 15 of the 17 individuals used drugs and/or alcohol, and ten were known to have distributed drugs. Many individuals had challenging family relationships, frequent missing person episodes, and demonstrated aggression and violence.

Table 10: *Characteristics of the children and young people supported by the caseworker*

Characteristic		No.
Patients referred		40
No. supported by the caseworker		17
No. who engaged		16
No. rated as good engagement		10
Sex		
• Male		
• Female		
Age	≤16 years	4
	17-18 years	7
	19-24 years	6
Statutory services involved		
• HMPPS		4
• YJS		4
• Social services		8
• LAC		5
Living in deprivation		15
No. visits per week	0	1
	1	8
	2	6
	3	2
Education and employment:		
• NEET		12
• Employment		2
• School / EOTAS / college		4
National Referral Mechanism (NRM)		8
Substance misuse		15
Dealing / distribution		10
Carries a weapon		5
Aggression / Violence		11
Family breakdown		13
Known associations to SOC/CE		14
Missing person episodes		9

Furthermore, the caseworker provides access to a range of interventions, including those aimed at improving their self-esteem, strengthening relationships, and emotional regulation and educating them on consequences of their behaviour.

Table 11: *Number of children and young people who have engaged with support and interventions*

Intervention type	No.
Individual work	14
Emotional regulation	11
Self-esteem	12
Relationships	12
Thinking and Behaviour/ Consequential thinking	13
Emotional and practical support to parents	12

Uned **Atal** Trais
Violence **Prevention** Unit

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