REPORT

Review of current practice in A&E Navigator programmes for youth violence prevention in England and Wales

Tom Roberts, Michael Whelan, Ryan McHenry, Rosie Cornish, Jade Levell, Brian McShane, Vera Braga Fernandes, and Christine Goodall

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University of Bristol

University of Glasgow

YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activity.

And just as important is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work, and we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together we need to look at the evidence and agree what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart it says that we will fund good work, find what works and work for change. You can read it here.

For more information about the YEF or this report please contact:

Youth Endowment Fund
C/O Impetus
10 Queen Street Place
London
EC4R 1AG

www.youthendowmentfund.org.uk

hello@youthendowmentfund.org.uk

Registered Charity Number: 1185413

About the research team

Authors:

Tom Roberts, Michael Whelan, Ryan McHenry, Rosie Cornish, Jade Levell, Brian McShane, Vera Braga Fernandes, Christine Goodall

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Abbreviations

A&E	Accident and Emergency
CAMHS	Child and Adolescent Mental Health Services
CYP	Children and young people
DASH RIC	Domestic Abuse, Stalking, and Harassment Risk Identification Checklist
ED	Emergency Department
FOI	Freedom of Information
HCP	Health Care Professional
KPI	Key Performance Indicator
MARAC	Multi Agency Risk Assessment Conference
MTC	Major Trauma Centre
RCEM	Royal College of Emergency Medicine
SARCS	Sexual Assault Referral Centre
SYV	Serious Youth Violence
TERN	Trainee Emergency Research Network
TU	Trauma Unit
VRU	Violence Reduction Unit

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2. Executive Summary of Findings

2.1. The Research Questions

We were tasked with exploring three key research questions.

Firstly, are A&E Navigator programmes in England and Wales distributed efficiently according to local need? Secondly, how do CYP with violence-related injuries engage with available A&E Navigator programmes? And lastly, what are the key criteria for successful A&E Navigator programmes?

The detailed findings in relation to each of the research sub questions can be found as a summary at the start of Chapters 4, 5 and 6 and these are further discussed in Chapter 8. Here we present a high-level overview of our research into A&E Navigator services in England and Wales.

2.2. Our Methodological Approach

This research study took a multiple methods approach to answer the research questions. The following methodological approaches were used:

- Literature review of A&E Navigator evaluations in England and Wales, to provide context for each research question from the existing evidence.
- Survey 1 - Mapping of available A&E Navigator services via a survey of Emergency Medicine Clinicians, established A&E Navigator services and Violence Reduction Units (VRUs), to map all available Navigator services in England and Wales
- Survey 2 - A prospective survey of active A&E Navigator services, to understand the models and service provision of active A+E navigator services
- Geospatial mapping of A&E Navigator services against deprivation, crime and violence rates and ethnicity, to visualise and better understand A+E Navigator availability.
- Interviews and focus groups with A&E Navigator services and stakeholders, to understand the service provision and models of active A+E navigator services

2.3. The Key Findings

2.3.1. Are A&E Navigator programmes in England and Wales distributed efficiently according to local need?

In general, Navigator services are aligned with areas of high potential need; areas with high deprivation and high crime rates. However, there remain high risk areas without a service, including areas of Wales, East England, East Midlands and the Southwest of England. Routinely collected data in England and Wales did not permit an assessment of the incidence of assault for children and young people.

Even when an A&E Navigator service is present in a hospital, children's access to support is affected by time of admission and programme eligibility criteria. Most A&E Navigator services operated during normal business hours (Monday to Friday 9-5), no identified services were available overnight. However, focus groups demonstrated that patients injured at night or at the weekends and admitted to hospital, particularly those who are more seriously injured, may be picked up by A&E Navigators on a ward in the following days. In terms of the clear remit of programmes to focus on 'serious youth violence' in practice we did observe a dichotomy between policy and practice in some programmes. The majority of A&E Navigator programmes supported CYP who presented with violence-related injuries or were considered at risk of involvement in violence. However, many also supported CYP with complex vulnerabilities such as exploitation, mental health crises or substance misuse, all of which may be associated with violence.

The demand and uptake of A&E Navigator programmes is not uniform across the UK. They are shaped by a complex interplay of location-specific factors, hospital infrastructure, funding models, and the degree of integration within clinical systems. Addressing these disparities requires targeted and sustained investment, improved system integration, and a commitment to equity in service provision.

2.3.2. How do CYP with violence-related injuries engage with available A&E Navigator programs?

Within the hospital setting, participation often begins at a moment of acute crisis, typically following a violent incident. CYP were referred to A&E Navigators from a range of sources. While most referrals were from ED staff, acute ward staff or a safeguarding lead or team, in some cases CYP self-referred or referrals came from family members. At other times A&E Navigators would proactively approach CYP in hospital. Once discharged from hospital the CYP could remain connected with the service in the majority of cases, only one service offered no outreach support. CYP could then receive ongoing support from the A&E Navigator service or could be referred onto community-based partner organisations. This ongoing support reflected the flexible youth-centred engagement provided by the A&E Navigator services. The type of support and length of support provided by different services varies considerably from emotional support through informal conversations, to more structured support programmes and from a one-off meeting in hospital to a longer engagement of up to 12 months.

Our literature review which included reports from 18 services revealed initial engagement with A&E Navigator services varied widely with between 17% and 88% of CYP taking up the initial offer of support. Ten services (the majority) reported a narrower range of engagement rates of between 34% and 75%.

Fifteen sites in our survey provided engagement rates for their service. These demonstrated that 60% of CYP engaged with those services initially and 80% of those CYP continued their engagement with the A&E Navigators beyond a first meeting. 80% of services pro-actively

approach CYP within hospitals but also within other clinical and non-clinical settings, including schools. 88% of those services contact CYP by phone following referral and, while this is thought to be a less effective means of first contact, it is useful particularly where CYP present at times when A&E Navigators are not on shift. Almost all A&E Navigator services who responded to our survey receive referrals from both safeguarding/child protection teams and ED clinical staff. Of note, from the 15 services who provided data, 40% of all referrals were for Female CYP.

Our literature review indicated that CYP remained engaged with services for variable lengths of time ranging from engagement only while in hospital to up to 12 months. Over half of the services responding to our survey (58%, n=29/50) were able to support greater than 6 months and only one service offered an in-hospital service only. The intensity of engagement of CYP with services varies significantly. Some interactions are described as deeply immersive and emotionally intense while others are brief and targeted. Across the range of professionals interviewed, value was placed on the ability of A&E Navigators to open conversations with young people that are difficult for other professionals to have.

Disengagement was associated with CYP not in education employment or training, difficulties in maintaining contact, chaotic lifestyles, parental involvement (which may be positive or negative) and severity of injury. All these factors may be predictive of both involvement and disengagement and mistrust of services due to experiences of marginalisation and systemic disadvantage. A key factor also noted in several publications was not having made initial face to face contact with the CYP and hence being unable to quickly establish as relationship with them. It was a challenge to determine whether these programmes can effectively engage CYP from minority ethnic communities due to inconsistencies in recording of ethnicity. This was seen both in our literature review and in our survey. A quarter (24%) of A&E Navigators services observed disparities in the engagement or outcome for racially diverse individuals with violence related injuries while 30% of services did not respond to this question. This highlights the need to better collect data on engagement and outcomes, including the effect of key characteristics like ethnicity and race.

2.3.3. What are the key criteria for successful A&E Navigator programmes?

Secure funding, face to face availability, integration within EDs and community links were all highlighted as key criteria for successful A&E Navigator programmes. Our research demonstrated the importance of the personal characteristics of individual A&E Navigators in cases deemed a success. Their non-clinical status allowed them to transcend professional barriers which can exist between clinical staff and their patients. A&E Navigators were viewed as being flexible, non-judgemental, trauma informed, person centred and collaborative.

A&E Navigator programmes described challenges both in relation to structural issues arising from their unique positions as external organisations within an NHS environment and in relation to their interactions with CYP. Within the NHS, A&E Navigators faced challenges relating to a lack of sustainable funding limiting opportunities to build a sustainable service,

lack of physical space to work in and poor integration into departments in some cases, this resulted in reduced visibility for teams which impacted on referrals. Some the A&E Navigator services had complex referral pathways requiring a lot of information from the NHS staff, limiting referrals. Successful integration on both sides clearly rests on an appreciation of the roles of each party.

Finally, 'defining violence' was cited as an issue by A&E Navigators. Where referral criteria were very strictly defined and limited to violence alone, often due to the way services were funded, other issues associated with hidden forms of violence or other significant harms could be missed. Integration into NHS teams, flexibility on the part of the Navigator service and a straightforward referral process supported strong collaboration with the NHS. A&E Navigator services are seen by clinicians and A&E Navigator staff to operate most effectively in delivering violence prevention when designed and operated as part of integrated services, working to tackle health inequalities at a population level. For A&E Navigator services to operate effectively, committed delivery teams are required, supported by consistent funding and allocation of staff time.

2.4. Conclusions

A&E Navigators are available in over a third of EDs in England and Wales. Most services have short term funding which hampers efforts to embed the services within EDs, to retain staff and to deliver sustainable support. Despite this they have evolved locally to offer wide ranging support to some of the most vulnerable CYP in society through their connections with health and in the wider community.

3. Introduction and background

3.1. Rationale for this study

A&E Navigator programmes have proliferated in England and Wales in recent years, with all 20 Violence Reduction Units (VRUs) having commissioned A&E Navigator programmes. The current government's commitment to place youth workers in EDs as part of their plan to tackle knife crime, alongside the £75m expansion of VRUs planned under the previous government, points to a policy environment likely to be supportive of investment in these programmes. (1)

Programmes have predominantly been implemented through collaborative partnerships between NHS Trusts and local voluntary or community-based organisations, with some operating via commissioned third-sector providers.

A&E Navigators provide social support to CYP within the ED and some services also provide support in the community on discharge from hospital. In addition to those services in England and Wales, similar services also exist in Scotland (www.mav.scot) and Northern Ireland (https://setrust.hscni.net/emergency-department-care-navigators-provide-social-care-life-line-for-patients/). Services in Scotland predominately provide support to either CYP under 16 or to adults over the age of 16, so are perhaps not directly comparable with the services in England and Wales.

Programmes place youth workers or similarly experienced/qualified professionals in Accident and Emergency (A&E) departments. A&E Departments are now more correctly known as Emergency Departments (EDs), the term used throughout. The aim of these programmes is to provide support to children and young people (CYP) who have been victims of violence. Although the existing evidence suggests that A&E Navigator programmes can have a high impact on violence, the evidence is very weak: the YEF Toolkit estimate is based on only two studies, both conducted in the United States. (2)

Despite the investment in A&E Navigator services by regional VRUs in recent years, there is no published central mapping of these services, it has not, therefore, been possible (prior to conducting this research) to report the availability of A&E Navigator services, or to assess whether they are located in areas of greatest need or the barriers they encounter during their set-up or day to day working.

Additionally, understanding what works in A&E Navigator services is an ongoing iterative process. Many services have been established over the last five years, meaning there is limited (though growing) understanding of their individual models of care. While it is inevitable that there will be some adaptation of the model to different local circumstances, there will also be common elements across A&E Navigator services. An improved understanding of both the common elements and the unique nature of each can inform the development of such services in the future and help to avoid duplication of effort when setting services up.

This report therefore sets out to understand where, when and how A&E Navigator services are available and to who. Following a review of the existing literature, which is integrated into

each chapter, it does this by concentrating on two main areas of enquiry. Firstly, mapping the catchment areas of existing A&E Navigator services against crime, deprivation statistics, ethnicity and, given the focus on CYP involvement in knife crime, against sharp force injury. Secondly, through an online survey distributed to A&E Navigator service leads and qualitative interviews and focus groups with a range of A&E Navigator stakeholders, the report aims to determine how the various regional A&E Navigator services operate and their criteria for success.

Understanding these elements of A&E Navigator services, and highlighting perceived successes and challenges, can offer a pathway to a more standard or consistent model of care. It also offers a clearer orientation for funders in developing practice frameworks and standards against which an assessment of effectiveness can be established. This is particularly pertinent in a context when funding for services such as A&E Navigators is often short term and precarious.

To fully understand the role and impact of A&E Navigator programmes, it is essential to situate them within the broader structural landscape of race in Britain. Racialised communities, particularly Black, Asian, and other minoritised groups, face disproportionate exposure to systemic disadvantage, including higher rates of poverty, over-policing, school exclusion, and underinvestment in youth services.(3) These inequalities are compounded by experiences of racialised criminalisation, where young people are more likely to be surveyed, monitored, or treated as inherently risky rather than in need of support (3). Public institutions such as the police, health services, and social care are often sites of mistrust for racialised children and young people, rooted in both historical and ongoing experiences of discrimination and harm. These dynamics play out in healthcare provision, which further shape access to care, with racialised populations facing disparities in mental health diagnosis, treatment, and outcomes (4). Together, these dynamics impact not only the risk of violence but also how services like A&E Navigators are perceived, trusted, and accessed by the groups that are most in need of them. Through the support of a race equity advisor, this report applies a race equity lens to understanding both engagement with and the outcomes arising from Navigator intervention.

Our research aimed to address the three main research themes and underlying questions set out below and to synthesise the results to produce a comprehensive picture and understanding of A&E Navigator services across England and Wales at the time of writing.

Theme 1. Are A&E Navigator programmes in England and Wales distributed efficiently according to local need?
1. How many 13–25-year-olds have been identified as having suffered an assault by sharp object between 2020-2025 in EDs in England and Wales (FOI)

2. To what extent do CYP with violence-related injuries have access to A&E Navigators in the ED?
3. How much of A&E Navigators' time is spent supporting CYP with violence-related injuries (vs supporting adults (those over the age of 25) or CYP hospitalised for other reasons)?
4. Does the demand and uptake of A&E Navigator programmes vary by location or hospital type?
5. What are the characteristics of hospitals that are more/less likely to benefit from A&E Navigator programmes? (e.g. whether the hospital was a MTC or TU)

Theme 2. How do CYP with violence-related injuries engage with available A&E Navigator programs?

6. What does participation involve, both in and beyond hospital?
7. How long do CYP remain engaged with the programme, and with what intensity for example is contact maintained after discharge, is this in person or by phone or are young people signposted towards other services?
8. What factors/characteristics related to the CYP or to the service predict participation and attrition rates (e.g. age, severity of injury, length of stay in hospital)?
9. Do participation and attrition rates vary according to CYPs ethnic background?
10. How can programmes effectively engage CYP from minority ethnic communities?

Theme 3. What are the key criteria for successful A&E Navigator programmes?

11. What are the characteristics of an effective A&E Navigator?
12. What challenges are experienced when implementing programmes and how can these be overcome?
13. Are there specific models/examples of best practice that could be adopted more widely?

3.2. Structure of this report

The report is organised into chapters, addressing each of the three research themes. All research questions will be answered in turn, drawing on findings from specific research methods as appropriate.

3.3. Purpose of the Report

This report aimed to map and understand how A+E Navigator services are delivered in England and Wales.

4. Methods

4.1. Literature review

The literature was sourced by hand searching and conducting a search on Google and Google Scholar. The search terms are set out in table 3.1 below.

Table 4-1 Literature review search terms

Search terms
A&E Navigators
A&E Navigator programmes
Major trauma care centre (reports)
Office of Violence Prevention
violence prevention (model) (programmes)
Local violent crime prevention
(Local) Violence Reduction Unit
Home Office evaluations of violence reduction programmes
Youth violence intervention
Emergency departments
Hospital-based interventions
Emergency departments treating violence related injuries
A&E attendance
Emergency admissions
Urgent care
effectiveness OR impact OR outcomes OR evidence OR engagement OR readmission
violence OR serious violence OR assault OR knife crime OR gun crime OR violent crime OR violence-related injuries OR reinjury
young people OR youth OR children OR adolescent OR teenager OR teen OR youth crime OR young adults

The exclusion criteria were publications prior to 2021 and research concerning Navigator programmes outside of England and Wales.

Some programmes have been the subject of multiple evaluations over the course of their implementation, in each case the inclusion of the most recent and up to date literature has been prioritised. The research questions were agreed with the Youth Endowment Fund. Drawing on published reports and evaluations from 39 hospitals (see Appendix 1), this

summary captures the nature of the A&E Navigator model, how it is delivered, the support offered to CYP and what challenges and successes have emerged. The content has been organised thematically providing insight and discussion around key features of the A&E Navigator interventions.

4.2. Mapping of available A&E Navigator programmes against potential need

4.2.1. Mapping of Emergency Departments in England and Wales

An existing Freedom of Information (FOI) request identified 173 EDs in England, three further EDs were identified through manual checking, one of which replaced a nearby adult-only ED for analysis, and two ED sites are known to have recently merged. (4) Publicly available data defines 12 EDs in Wales, giving a total of 186 ED sites for analysis. EDs were stratified by trauma-receiving status, between those sites with Major Trauma Centre (MTC) designation (27 in total in England: 22 adult centres of which 11 also act as MTC for children and 5 additional MTC for children and one in Wales), and those without.

4.2.2. Mapping of A&E Navigator Services in England and Wales

Three methods were used for identifying A+E Navigators in England and Wales. All used a Navigator mapping survey designed for this purpose to identify active A&E Navigator services.

1) Using the Trainee Emergency Research Network (TERN) infrastructure, the mapping survey was disseminated to 1343 participants, all of whom work with EDs.
2) An email was sent to VRU directors of areas where data was missing asking for the mapping survey to be distributed to any active A&E Navigator services.
3) A+E Navigator services who engaged in the mapping work, were asked to disseminate the mapping survey onto other known sites.

The A&E Navigator mapping survey received 223 responses. After removal of duplicates 144 individual sites responded either Yes or No (77% of the total of all EDs) to the presence or absence of A&E Navigator services at their site at the time of the survey.

4.3. Geospatial modelling of hospital catchments against potential need

Modelling catchment areas for individual hospitals is complex (5), and there is no national resource listing EDs nor defining their catchment areas. While travel time metrics give a best approximation of the areas served by each hospital, with benefits over straight line distance (6), they are unlikely to reflect the place of care for all patients. Travel time modelling makes no distinction between the level of care provided in each ED, for example whether they are of MTC or Trauma Unit (TU) Status.

Modelled catchment areas were created for each ED in England and Wales, from the population-weighted centroid (the centre point of a population in any given area taking into account the population density in the area) of each Lower Super Output Area (LSOA) (these are geographical areas used for statistical reporting that have relatively consistent population sizes) to the ED that may be reached in the shortest time by road. Travel times were derived from OpenSource Routing Machine (OSRM) geospatial modelling, which determines travel time from the character and distance of route. As the NHS in England and Wales are separate organisations, geographic modelling was performed on a national basis. Given the focus on youth population, where data is available for Paediatric EDs co-located, or closely located, with adult centres, the Paediatric ED location was used.

4.3.1. Metrics Describing Local Need

The question of 'local need' is complex. Defining each region's 'need' for an A&E Navigator service was beyond the scope of this research; however, the presence or absence of A&E Navigator programmes have been mapped against key datasets that provide a proxy marker for the 'potential' need for an A&E Navigator programme. These include deprivation, crime and violence rates per 100 population.

The following data were obtained for each LSOA:

1) Police crime statistics for 2024: total crime counts and violent crime counts obtained from the Police Data Portal (7). Crime rates were calculated per 100 population for each LSOA.
2) Index of Multiple Deprivation (IMD) rank including overall decile, and decile of the crime domain[1] (8)
3) National census data from 2021, defining population numbers.

An FOI Request was submitted to NHS England and Wales to identify the number of patients presenting to EDs with assault by sharp object by NHS hospital trust, age group and ethnicity.

Navigator availability was also mapped against national census data from 2021, describing high-level ethnicity by LSOA to determine the association between local ethnic diversity and access to Navigator services.

[1] IMD is a composite metric, aiming to capture multiple factors contributing to socioeconomic deprivation, including crime, employment, income and housing. There are separate indices for England and Wales but these aim to assess similar outcomes (318. Abel GA, Barclay ME, Payne RA. Adjusted indices of multiple deprivation to enable comparisons within and between constituent countries of the UK including an illustration using mortality rates. BMJ Open. 2016;6(11):e012750.. The IMD is commonly analysed as deciles, with 1 constituting the most deprived 10% of areas, and 10 describing the least deprived 10%.

4.3.2. Statistical analysis

We conducted two analyses. In the first, analysis was carried out at the LSOA level, with each LSOA categorised according to the presence or absence of an A&E Navigator at their "nearest" ED according to the mapping described above. In the second, analysis was carried out at the modelled catchment area level, with the above statistics aggregated across all LSOAs within each of these.

The population-weighted mean IMD decile and mean crime domain decile for each modelled catchment area was calculated, alongside total and violent crime rates per head of local population, and local ethnic diversity. As IMD is a national metric, with separate indices for England and Wales aiming to assess similar outcomes, all calculations involving IMD were first performed on a national basis, then aggregated for analysis. Population characteristics, stratified by presence or absence of A&E Navigators, are described as medians with interquartile range (IQR).

Following this, univariable logistic regression was used to assess the association between A&E Navigator presence and each of the metrics under consideration. This analysis was undertaken at the LSOA level with robust standard errors to take account of non-independence of LSOAs within the same hospital catchment and at the hospital (ED) level. The results are expressed as odds ratios with 95% confidence intervals (95% CIs), which are interpreted as the change in likelihood of A&E Navigator presence with each increment of exposure metric.

To identify A&E Navigator coverage in those EDs with the highest likely needs, the final analysis concentrated on the 20 EDs with the most deprived catchment areas and highest rates of local violent crime, reporting the number and proportion of these services with and without A&E Navigator services.

Due to the thorough search for A&E Navigator services, the primary analysis assumed that sites who did not respond to the survey and had not been identified via discussion with VRUs and/or implementing partners did not have A&E Navigator services. A secondary analysis removed these non-responding sites so that the analysis focussed on sites where there was an active A&E Navigator service.

4.3.3. Visualisation

Mapping was undertaken to identify areas with and without A&E Navigators, with additional bivariate mapping identifying areas of relative potential need and their availability of A&E Navigator services. This mapping was conducted for each modelled ED catchment area.

4.3.4. Prospective survey of Active Navigator Services

The survey was designed, developed and disseminated using the Checklist for reporting results of internet E-surveys (CHERRIES). (9)

4.3.5. Ethical approval and consent

Ethical approval was granted by the University of Bristol Faculty of Health Sciences Research Ethics Committee (ref: 23474). All participants across the survey, focus groups and interviews were provided with a participant information sheet outlining pertinent information, and participants were required to provide written consent confirming their informed consent to participation in the research.

4.3.6. Survey design

This was a prospective survey of known A&E Navigator Services, identified during the initial mapping study and emails to VRU Directors outlined above. The survey was a 78-item questionnaire. There was no randomisation of questions but branching logic was used to minimise survey fatigue. The survey was one continuous survey, without pagination. A completeness check was built into REDCap and only on the completion of all survey items was the survey marked as complete. Individuals could edit the survey whilst in the survey and each respondent also received a return code, to edit the survey later if required. There was a specific section exploring the organisational approach to race equity.

The survey was developed in conjunction with the study team who have extensive experience in youth work, serious youth violence, EDs and A&E Navigator services. It was further reviewed by the Youth Endowment Fund and the project's Race Equity Associate. Prior to dissemination it was tested amongst the study team.

4.3.7. Recruitment process

This was an open survey accessed via a link to the REDCap survey. However, the link was only distributed to known A&E Navigator Services via direct email contact. These emails were provided at the mapping stage by services themselves or were accessed via freely available reports or website about the service. No social media or wider campaigns were used to encourage completion. This was to minimise the risk of false submissions. The survey was voluntary for staff at each A&E Navigator service, however, a prize draw incentive of £50 in Amazon vouchers was offered. The survey was opened on 15th April 2025 and closed on 6th June 2025.

4.3.8. Data collection and storage

The survey was administered using REDCap and stored on secure University of Bristol servers. Only the owner of the database (Dr Tom Roberts) had access to submitted data. REDCap provides a clear audit log of all interactions with the database and is password controlled to ensure no unauthorised access.

4.3.9. Response rates

The denominator for the response rate to the survey is 74 A&E Navigator services. We also report the participation rate, calculated by the number of people who agreed to participate, divided by those who completed the survey.

4.3.10. IP Check

IP checking can be used to identify duplicate data entries from the same individual. This was not performed in this study as each site had to identify themselves as a hospital, so duplicates could be identified through this method.

4.3.11. Analysis

Each item in the questionnaire was analysed independently. Those surveys which have data entered for a specific item were analysed, irrespective of completion status of the entire survey. Analysis was descriptive, aligned to the specific research questions outlined in the research questions table.

4.4. Focus groups and Interviews

This section provides an overview of the qualitative component of the research, which explored the perceptions of four key stakeholder groups in relation to the practice models and approaches employed by A&E Navigator services, and their successes and challenges. The intended stakeholder groups were CYP/service users, A&E Navigators, A&E Navigator service lead staff and Health Care Professionals (HCPs). Two qualitative research methods were used- focus groups and interviews- which are discussed in more detail below. The focus groups involved lead staff from a range of A&E Navigator services across England and Wales, while interviews were conducted at five interview sites involving participants from across the stakeholder groups. The qualitative research process can be divided into four key phases, as discussed below.

4.4.1. Phase One: Planning and Preparation

In this phase of the study, the qualitative research team ensured that mechanisms were in place to begin the data collection process. This phase included a review of themes from the literature review, an application for ethical approval (University of Bristol Faculty of Health

Sciences Research Ethics Committee (ref: 23474)) and a steering group meeting. Key themes from the questionnaire and the literature review (as they emerged) informed some of the themes explored within the focus groups and interviews.

4.4.2. Phase Two: Data Collection and Analysis 1- Focus Groups

The first round of data collection involved running two focus groups with lead staff from A&E Navigator delivery organisations (n= 7). Participants were recruited from A&E Navigator projects from across different parts of England, through a combination of direct e-mails to known projects, and the inclusion of an expression of interest question in the survey. A key strength of the focus groups was their ability to bring together multiple perspectives from across different services in diverse locations (Tables 3.2 & 3.3).

Interviews (n=28) were conducted at 5 interview sites (some of which had more than one delivery site)- Manchester (5 delivery sites), Hampshire (4 delivery sites), Leeds (2 delivery sites), Cardiff (1 delivery site) and Royal London (1 delivery site). Interview and focus group data was analysed thematically, and themes were mapped against each of the research questions. Interview data was also used to compile interview site profiles, outlining key features of the service delivery model at each of the 5 interview sites (see chapter 5).

The demographics of the participants for the focus groups and interviews is presented in table 3.2 and an overview of stakeholder group participants within focus groups and interviews in table 3.3. In terms of diversity, the focus group participants were slightly more ethnically diverse than the general UK population, however we recognise that hearing from more diverse voices may have been beneficial here due to the racial disproportionality in relation to CYP involvement in violence and violence victimisation.

Discussions within the focus groups provided a valuable insight on the emerging consensus (or lack of) in relation to key areas of A&E Navigator success and challenges, and the related practice models contributing to these outcomes. The insights from these discussions then fed into more in-depth and specific discussions within the second stage of data collection- the interviews.

Table 4-2 Demographics of participants of focus groups and interviews

			Ethnicity					
	n	Female, Male	White	Asian or Asian British	Black, Black British, Caribbean or African	Mixed or Multiple	Other	Not known
Focus Group								
FG1	3	2F, 1M	1	-	-	1	-	1
FG2	4	4 F, 0M	4	-	-	-	-	-
Interview Sites								
IS 1	6	2F, 4M	4	2	-	-	-	-
IS 2	9	7F, 2M	6	1	-	1	-	1
IS 3	6	5F, 1M	4	-	-	-	-	2
IS 4	4	3F, 1M	3	-	1	-	-	-
IS 5	3	1F, 2M	1	-	-	2	-	-

Table 4-3 Focus groups and interviews by stakeholder groups

		Stakeholder Group				
	n	A&E Navigator Service Lead Staff	A&E Navigator	Health Care Professional	Young People	Other
FG1	3	3	-	-	-	-
FG2	4	4	-	-	-	-
IS 1	6	1	3	2	-	-
IS 2	9	2	3	2	-	2 parents of young people impacted by violence
IS 3	6	1	3	1	-	1 social prescriber
IS 4	4	1		2	-	1 third sector partner case worker
IS 5	3	1	1	1	-	-

4.4.3. Phase Three: Data Collection and Analysis 2- Interviews

Interviews were conducted across five A&E Navigator sites: Cardiff, Leeds, London (Tower Hamlets), Manchester and Hampshire (n=28). The choice of these sites ensured representation from both England and Wales, in addition to offering diversity in relation to a

range of additional considerations, such as geographic spread, staffing, numbers of CYP worked with, practice model adopted and length of time since being established. At each interview site, we sought to interview people from each stakeholder group, with the aim of conducting between 4 and 8 interviews in total at each site. We met this aim for all stakeholder groups except CYP (see participant table 3.3).

A purposive sampling approach was adopted, with particular attention given to race equity considerations. Interview participants were recruited via the A&E Navigator delivery organisations in each of the identified sites. A semi-structured interview approach was adopted, allowing a level of flexibility for participants to highlight areas that might not have been expected, whilst also retaining an orientation to the core research questions.

4.4.4. Phase Four: Data Analysis

The research team triangulated insights from across the focus groups and interviews, adding robustness to the analysis process by reviewing and consolidating themes identified across researchers and across data sets (10). Data from the interviews and focus groups was analysed by thematic analysis (11). AI ('Copilot') was used to support with the initial thematic analysis of interview and focus group data (12, 13). This involved the use of Copilot to identify initial themes, related codes and indicative quotes. These were then reviewed, consolidated and written up by the research team. One interview site was analysed without the use of AI, for comparison purposes. The separately analysed site did not point to any notable gaps or limitations in the AI analysed themes.

5. Are A&E Navigator programmes in England and Wales distributed efficiently according to local needs?

5.1. Chapter Summary

This chapter explores the distribution of A&E Navigator services in England and Wales and seeks to determine whether they are located according to local needs. To answer this, we also explored the following sub questions.

- How many 13–25-year-olds have been identified as having suffered an assault by sharp object between 2020-2025 in EDs in England and Wales? (Section 4.7)
- To what extent do CYP with violence-related injuries have access to A&E Navigators in the ED? (Section 4.8)
- How much of A&E Navigators' time is spent supporting CYP with violence-related injuries (vs supporting adults or CYP hospitalised for other reasons)? (Section 4.9)
- Does the demand and uptake of A&E Navigator programmes vary by location or hospital type? (Section 4.10)
- What are the characteristics of hospitals that are more/less likely to benefit from A&E Navigator programmes? (Section 4.11)

To address the underlying questions about access, demand and availability we looked across the different methodological elements of this study.

Our review of the literature found 18 publications relating to the evaluation of A&E Navigator services in England and Wales that had been published after 2021 (see Appendix 1). Fifteen of the available publications were service evaluations or programme reports and were not published in peer reviewed journals. These publications cover 39 different individual hospitals. A number of these services have been cut since their evaluations. There were no published studies looking across England and Wales to identify all existing services or which mapped their distribution according to need.
The initial mapping survey of A&E Navigator sites identified 74[2] hospitals with active A&E Navigator programmes (Appendix 2). This equates to 72 sites in England and two services in Wales. These results were accurate as of March 2025.

When A&E Navigator services were mapped against deprivation, crime and ethnicity metrics for each modelled ED catchment area in England and Wales, it was seen that:

- 14/20 (70%) of the EDs with the highest local levels of deprivation had an A&E Navigator service

[2] For mapping purposes, the Adult and Children's hospitals in Portsmouth and Manchester were combined. This could be separated to provide 76 A+E navigator services.

- 13/20 (65%) of the EDs with the highest local levels of overall violent crime had an A&E Navigator service
- 12/20 (60%) of the EDs with the highest local levels of overall crime had an A&E Navigator service.

Despite the proliferation of A&E Navigator services there are still large areas of England and Wales with no A&E Navigator service availability. These were the Southwest, East Midlands, East of England and mid and North Wales. We also noted that several areas of high socio-economic deprivation or high crime rates did not have an A&E Navigator service meaning that CYP who were affected by violent crime may not benefit from the service.

When looking at distribution of A&E Navigators in terms of ethnicity, services do seem more likely to be available in areas where there are larger minority ethnic populations and that may be related to the intersection of ethnicity with deprivation, however, this does not necessarily mean that those populations are more likely to need the service or to use it if offered.

Alongside this routinely collected data on sharp force assault showed that the number of attendances in England has increased over the period 2020-24 for both 13–17-year-olds and 18–25-year-olds while the number of admissions in Wales has fallen over the same period for 13–25-year-olds. The 32 A&E Navigator services that responded to the survey reported seeing 9795 patients over a 12-month period which equates 0.84 patients per day across those services, a number far higher than the reported number of CYP presenting with injuries due to sharp force assault and one which demonstrated a daily demand for these services.

There are several possible reasons for the discrepancy noted between routinely collected data and that reported in our survey. One is that the routinely collected data is unlikely to reflect the entire scale of the problem as it relies on correct and complete coding of all ED attendances so the numbers presenting with sharp force injury may be higher than recorded. Another is that, as seen in the survey, many A&E Navigator services offer a wide range of supports and do not focus all their efforts on 'serious violence' which may additionally account for some of the gap between the numbers presenting with sharp force assaults and those seen by the A&E Navigators. Some services noted that creating very strict boundaries around their referral criteria was challenging, that violence came in many forms and was often connected to other social issues adding to the challenge of restricting a service. Building trust with CYP and their families sometimes offered the opportunity to uncover underlying violence or risk that was not initially evident.

There were several factors noted in the survey and focus groups that pointed towards improvements that could be made to enhance access to services for CYP. Those included increasing the hours of availability of the services, most operated during normal business hours with only 30% available on weekends. No services were available overnight. Most violence related trauma presents out of hours or at weekends. Some services noted in the

survey and focus groups that they tried to offer some flexibility but there were contractual restrictions that came into play.

Another challenge that some A&E Navigator services faced was that of embedding themselves fully into the ED. The high turnover of staff and lack of knowledge about the service among some NHS staff meant that for some CYP referrals to the A&E Navigators were not made.

Lastly, when we looked at category of hospital, we found that A&E Navigators services are available in two thirds of MTCs but only one third of TUs or local Emergency Hospitals. The average number of patients seen by A&E Navigators in adult MTCs annually was 411 and the number in TUs was approximately two thirds of that amount at an average of 278 annually. We were unable to access data for the majority of paediatric MTCs, so the MTC number here is likely an underestimate of the total figure. A complex interplay of geographical and logistical factors can affect the availability of A&E Navigator services to CYP within these hospital types. A&E Navigators in MTCs may see more young people who have been victims of 'serious violence' but they may not always be the CYP most in need of support. Addressing these disparities requires targeted and sustained investment, improved system integration, and a commitment to equity in service provision.

5.2. Mapping

There is no existing published source that maps A&E Navigator services across England and Wales

Among the 186 EDs identified (174 in England, 12 in Wales), we identified an A&E Navigator service in 74 (72 in England, 2 in Wales). Out of all EDs, 37 either did not respond to the survey or were not otherwise identified as having an A&E Navigator service; these were all in England. Figure 4.1 shows a map of catchment areas according to presence or absence of Navigator service and Figure 4.2 shows a breakdown for London. These figure highlights areas of the UK where A&E Navigators are not present, including the Southwest, East Midlands, East of England and mid and North Wales.

Figure 5-1 Presence of A&E Navigators in England and Wales

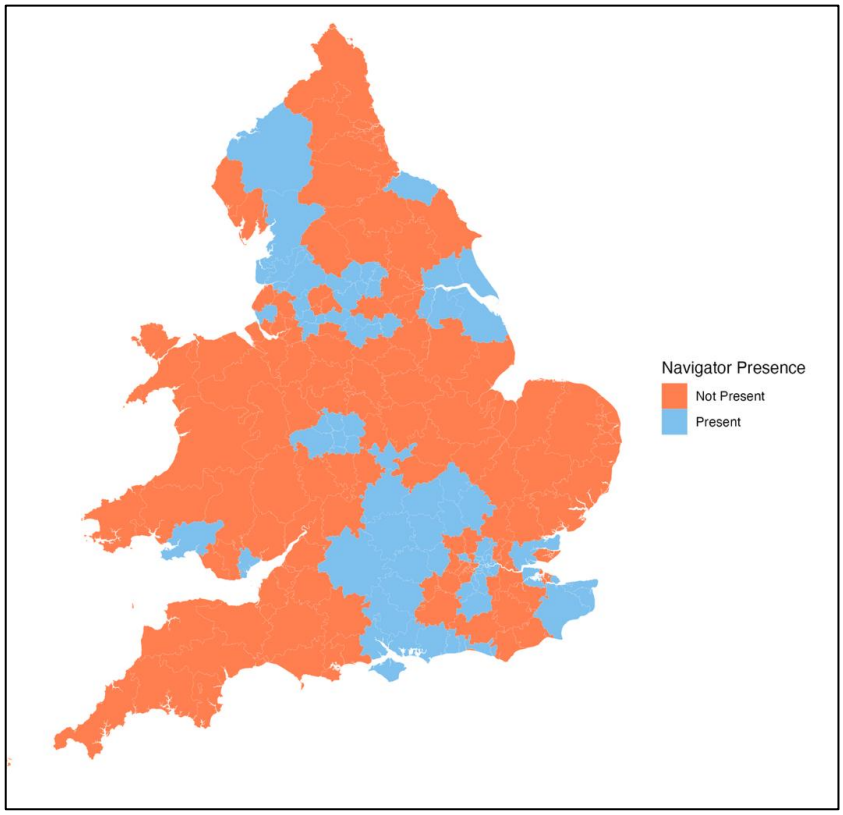
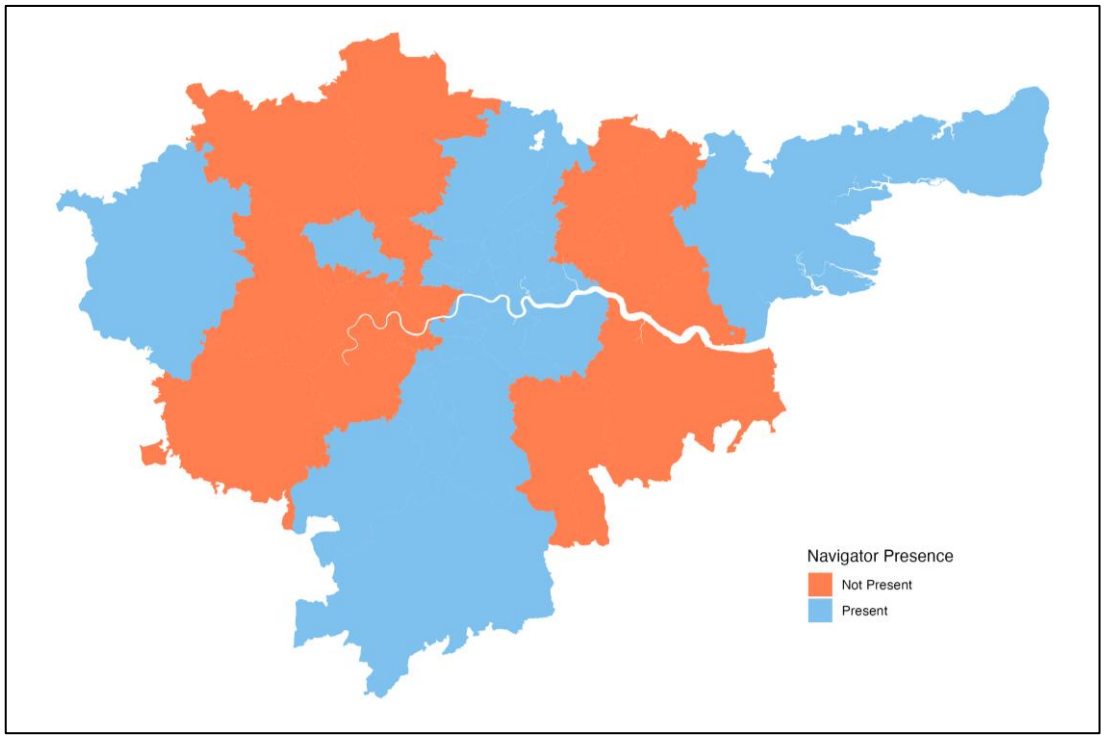


Figure 5-2 Presence of A&E Navigators in London



5.3. A&E Navigator presence by deprivation, crime and ethnicity by LSOA

We mapped A&E Navigator presence against various metrics, deprivation, crime and ethnicity which we postulated might relate to elements of local need for hospital-based violence intervention programmes such as A&E Navigators. Table 4.1 reports the proportion of LSOAs with an A&E Navigator service at their identified ED, according to deciles of each metric. This is supported by Table 4.2 which gives odds ratios (per decile) for each of these characteristics. As indicated in the methods section, these results assume that sites who did not respond to the survey and had not been identified via discussion with VRUs and/or implementing partners did not have A&E Navigator services. Results from the secondary analysis omitting these non-responding sites are given in Appendix 3.

During the mapping survey of A&E Navigator services, performed after April 2025, we became aware of at least four A&E Navigator services that were active up until the end of March 2025 but, due to funding cuts, were not renewed after April 2025, these were retained in the analysis.

Table 5-1 Presence of A&E Navigator service by deciles of each characteristic (n=34,753 LSOAs; 187 EDs; range of 1-479 LSOAs per ED, median=178 LSOAs)

Characteristic	Decile	Proportion of LSOAs with A&E Navigator service at nearest ED	Characteristic	Decile	Proportion of LSOAs with A&E Navigator service at nearest ED
Index of Multiple Deprivation (IMD)	Least deprived	40%	Crime rate per 100,000 population	Lowest	35%
	9	38%		2	36%
	8	39%		3	37%
	7	39%		4	41%
	6	38%		5	43%
	5	40%		6	44%
	4	44%		7	44%
	3	48%		8	46%
	2	50%		9	48%
	Most deprived	53%		Highest	50%
IMD crime domain	Lowest crime	29%	Violence rate per 100,000 population	Lowest	40%
	9	33%		2	37%
	8	37%		3	38%
	7	39%		4	40%
	6	42%		5	43%
	5	45%		6	45%
	4	48%		7	43%
	3	50%		8	43%
	2	51%		9	46%
	Highest crime	54%		Highest	50%

LSOAs in more deprived areas, and those with higher overall crime and violence crime rates were more likely to have an A&E Navigator service at the identified ED (Tables 4.1 and 4.2). This indicates that A&E Navigator services are located in areas where there is a higher incidence of violence and overall crime. These may be linked to the level of deprivation, as levels of violence have been found to increase with deprivation (14). The trend of increasing likelihood of having an Navigator service was weaker for overall IMD compared to the IMD crime domain (for example 53% of LSOAs in the most deprived overall IMD decile had a Navigator service compared to 40% in the least deprived decile, whereas the corresponding figures for the IMD crime domain were 54% and 29%) and weaker for rates of violent crime compared to overall crime (Tables 4.1 and 4.2). The results omitting EDs which did not respond to the survey or were not otherwise identified as having an A&E Navigator service were broadly similar in terms of trends according to this set of characteristics (Appendix 3).

Table 5-2 Univariable logistic regression for presence of A&E Navigator for each explanatory variable

Characteristic	OR (95% confidence interval)
Index of Multiple Deprivation (IMD)[1]	0.94 (0.89, 0.98)
IMD crime domain[1]	0.89 (0.85, 0.94)
Crime rate per 100,000 population	1.07 (1.03, 1.11)
Violence rate per 100,000 population	1.05 (1.01, 1.08)
Notes: where not already in deciles, each variable was categorised into deciles so that odds ratios were on the same scale (i.e. per 1 decile increment). Decile 1 = most deprived, decile 10 = least deprived, so OR is for increasing deprivation.	

5.4. A&E Navigator presence by deprivation, crime and ethnicity by modelled hospital catchment area

Summary statistics for the modelled catchment areas of sites with and without an A&E Navigator service are shown in tables 4.3 and 4.4. These mirror the findings from the above analysis at LSOA-level, with stronger associations with presence of A&E Navigator services seen for the IMD crime domain than overall IMD and with overall crime compared to violent crime rates.

Table 5-3 Summary characteristics of modelled catchment areas for sites with and without A&E Navigator presence, assuming no A&E Navigator presence in sites without confirmed A&E Navigator.

Characteristic	**Overall** N = 186	**Not Present** N = 112	**Present** N = 74
Population-weighted IMD Decile	5.50 (4.58, 6.40)	5.71 (4.89, 6.47)	4.98 (4.14, 6.03)
Population-weighted Crime IMD Decile	5.55 (4.54, 6.80)	6.12 (5.04, 7.13)	4.86 (3.80, 5.91)
Total Population	300,135 (214,096, 403,138)	273,167 (203,589, 366,377)	327,272 (229,261, 429,152)
Total Population Under 16	57,814 (39,869, 77,926)	52,791 (37,331, 71,827)	64,024 (48,432, 87,717)
Median IMD Decile	5.00 (4.00, 7.00)	6.00 (5.00, 7.00)	5.00 (4.00, 6.00)
Median Crime IMD Decile	6.00 (4.00, 7.00)	6.00 (5.00, 8.00)	5.00 (4.00, 6.00)
Annual Crime per 100 Population	8.86 (7.33, 10.71)	8.36 (7.00, 9.80)	9.93 (7.95, 11.40)
Unknown Annual Crime	15	8	7

Annual Violent Crime per 100 Population	3.16 (2.54, 3.71)	3.14 (2.49, 3.57)	3.34 (2.60, 4.06)
Unknown Annual Violent Crime	15	8	7
Ethnic Diversity (as Percentage White Population)	94 (85, 97)	96 (91, 98)	86 (71, 94)
Major Trauma Centre	27 (100%)	8 (29.6%)	19 (70.4%)
Trauma Unit/Local Emergency Hospital	159 (100%)	104 (65.4%)	55 (34.6%)
IMD – Index of Multiple Deprivation; IQR – Interquartile Range			

Logistic regression demonstrated an association between A&E Navigator presence and weighted mean IMD decile of modelled catchment area, with a greater likelihood of A&E Navigator services in EDs with a more deprived catchment area, and in catchment areas of greater crime-specific deprivation. Areas facing a higher burden of both total crime and violent crime were more likely to have access to A&E Navigator services. Results were consistent between the primary and secondary analyses. Sites without MTC designation were less likely to have A&E Navigator services (Table 4.4). The odds ratio may be interpreted as the extent to which the likelihood of A&E Navigator presence changes for each step up of each of the characteristics under consideration. For example, for each additional violent crime per 100 of the local population, the likelihood of the ED having A&E Navigator availability increases by approximately 74%; demonstrating that, in general, A&E Navigator services are more available in areas of higher violent crime.

Table 5-4Univariable logistic regression for presence of A&E Navigator for each explanatory variable

Characteristic	**Odds Ratio (95% Confidence Interval) for A&E Navigator Presence**
Population-weighted mean IMD decile (each increment less deprived)	0.70 (0.54-0.89)
Population-weighted mean crime domain IMD decile (each increment less deprived)	0.58 (0.46-0.72)
Annual crime per 100 (2024)	1.23 (1.09-1.40)
Annual violent crime per 100 (2024)	1.74 (1.20-2.58)
Trauma-receiving Designation	

MTC	Reference
TU/Local Emergency Hospital	0.22 (0.09-0.52)

The following figures 4.3 to 4.6 show bivariate maps of A&E Navigator presence or absence against high potential need. Areas in red indicate the modelled catchment areas for EDs without A&E Navigators. Areas in blue indicate A&E Navigator presence. The darker the colour (red or blue) indicates increasing potential need for each variable. Areas of dark red are those without A&E Navigator but with high levels of potential need.

Figure 5-3 Map of violent crime rates and A&E Navigator presence in England and Wales

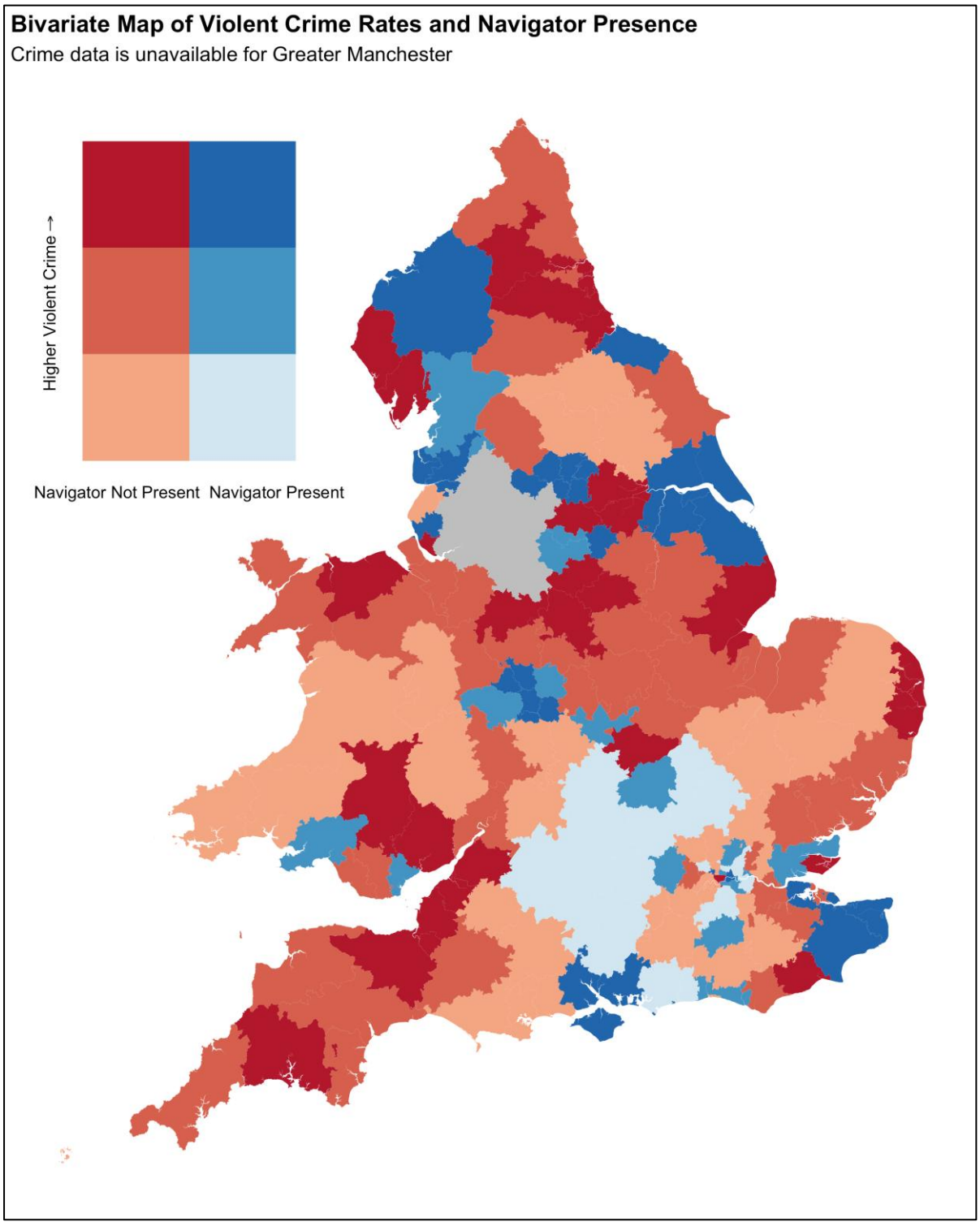
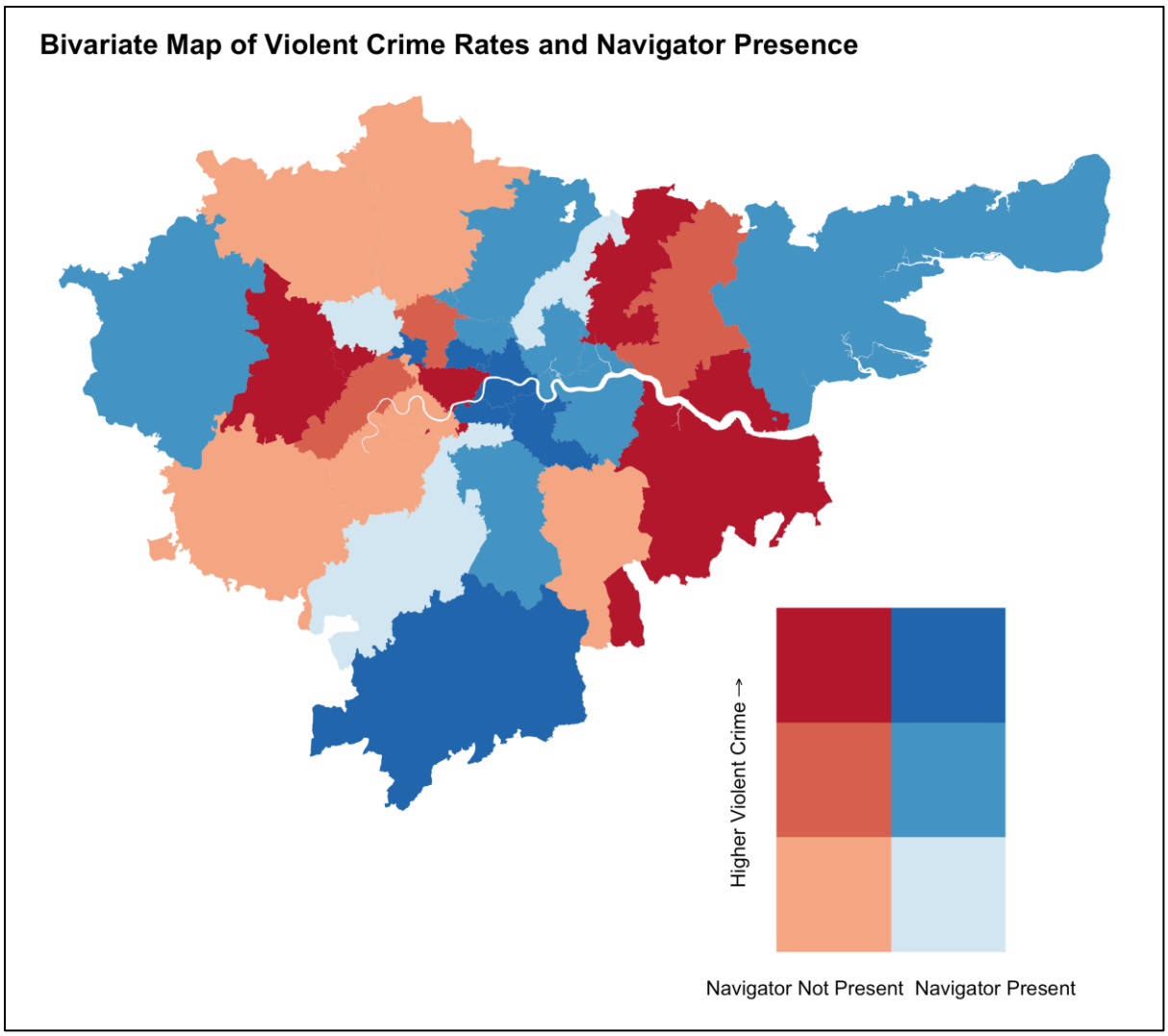


Figure 5-4 Map of violent crime rates and A&E Navigator presence in London



These maps demonstrate a range of met, and unmet, potential needs; from areas with high rates of violent crime without A&E Navigator in their local ED in dark red, to those of relatively lower rates of violent crime, but with A&E Navigator access, in light blue.

Figure 5-5 Map of weighted mean IMD decile and A&E Navigator presence in England and Wales

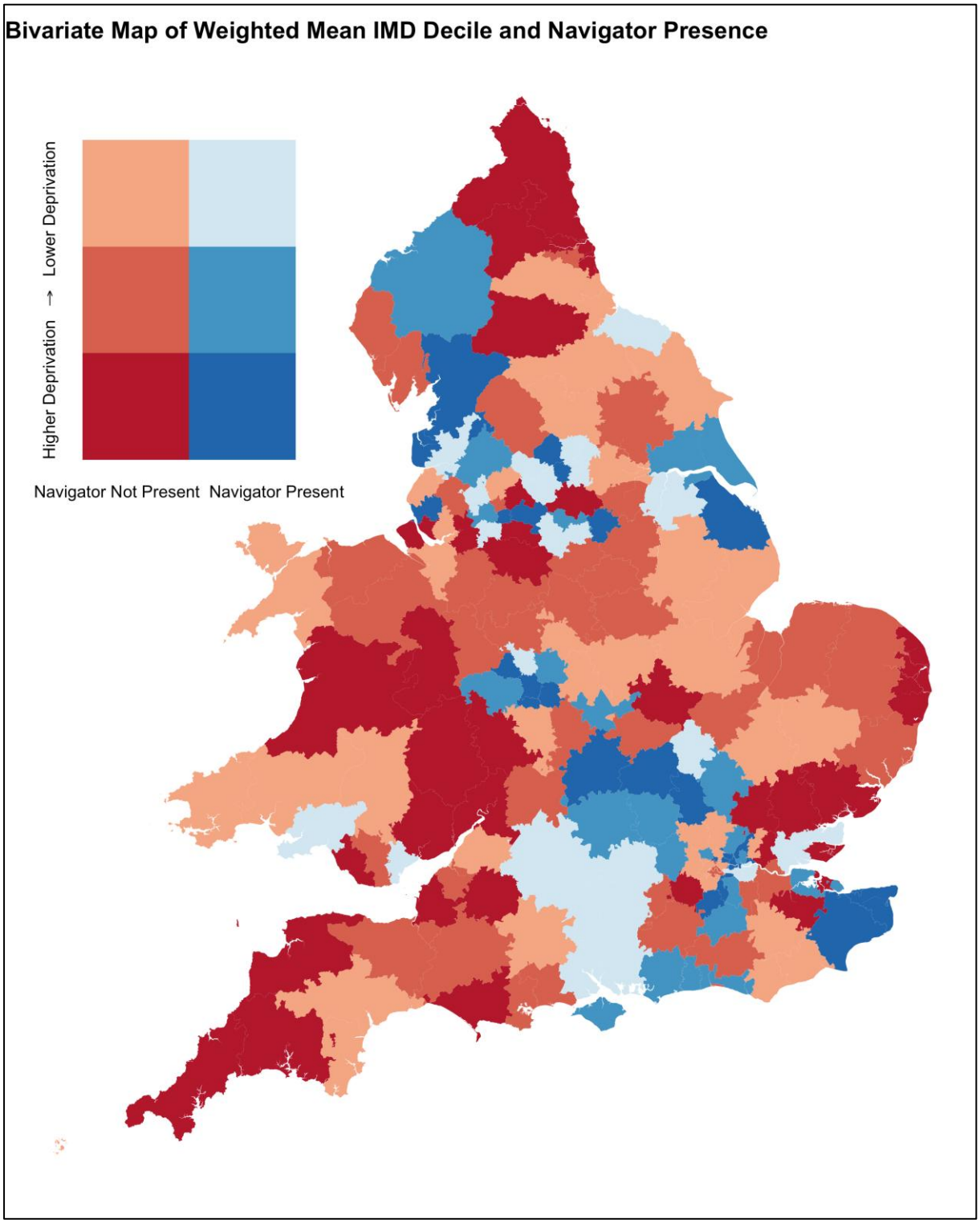
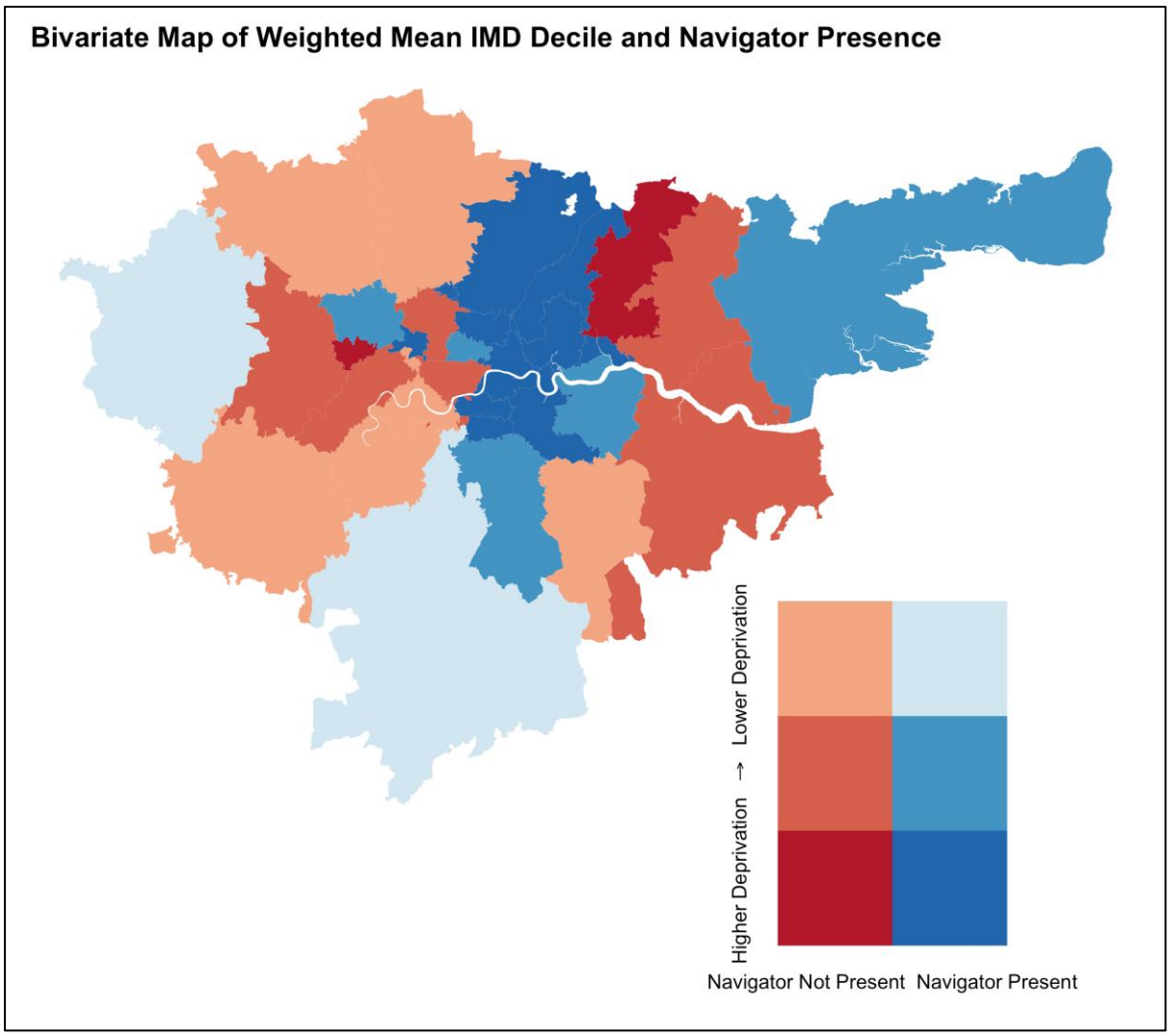


Figure 5-6 Map of weighted mean IMD decile and A&E Navigator presence in London



These maps demonstrate areas with higher socioeconomic deprivation without A&E Navigators in their local ED in dark red, to those whose modelled catchment areas are of relatively lower total deprivation, but with A&E Navigator access, in light blue. While different metrics produce different estimates of potential local needs, the areas of higher needs are broadly stable between crime and deprivation metrics.

An interactive map of all the above data is available here: https://youthendowmentfund.org.uk/Nav_Map.html

5.5. Areas of potential future need

As a final analysis table 4.5 highlights the number and proportion of EDs without an A&E Navigator service, from the 20 areas hypothesised to have the highest need. This data can be used by policy makers to track how roll-out of A&E Navigators have aligned with the populations most likely to need them.

Table 5-5 Number of EDs without an A&E Navigator service, of the 20 EDs with greatest potential need

Characteristic	Number without A&E Navigator services of the 20 EDs with greatest potential need
Most deprived by population-weight IMD decile	6 (30%)
Most effect of crime by population-weighted crime domain IMD decile	5 (25%)
Highest annual crime	8 (40%)
Highest annual violent crime	7 (35%)

The EDs whose modelled catchment areas experience the highest levels of violent crime per 100 population are presented below. Those without identified access to A&E Navigators at the time of review are presented in bold. Limitations of the methodology, particularly in the lack of crime statistics available for Greater Manchester, should be acknowledged in the interpretation of these results.

St James's Hospital, Leeds
Bradford Royal Infirmary
Leeds General Infirmary
Midland Metropolitan University Hospital
Blackpool Victoria Hospital
Calderdale Royal Hospital
Pinderfields Hospital, Wakefield
Dewsbury and District Hospital
Glan Clwyd Hospital
The James Cook University Hospital
Alder Hey Children's Hospital, Liverpool
Queen Elizabeth Hospital Birmingham
Diana Princess of Wales, Grimsby
South Tyneside District Hospital
University Hospital of North Tees
Chelsea and Westminster Hospital
New Cross Hospital
Heartlands Hospital
Doncaster Royal Infirmary
Bristol Royal Infirmary

5.6. Survey, Interviews and Focus Groups

The survey did not make assessments of local need. However, we can report the number of referrals sites received in the last 12 months. This data entry was voluntary. 64% of services (n=32/50) submitted data.

There were 9795 referrals across the 32 sites. The equates to a mean of 306.1 CYP referred at each site over 12 months, or an average of 0.84 CYP per site per day (including weekends).

Whilst this data does not demonstrate need, it does demonstrate a demand for A&E Navigator services.

5.7. How many 13–25-year-olds have been identified as having suffered an assault by sharp object between 2020-2025 in EDs in England and Wales?

5.7.1. Mapping and Freedom of information requests

The data presented below is from Freedom of Information (FOI) requests from England (ref: 2502-2192243) and Wales (ref: 5879146)

Figures 4.8. and 4.9 report the number of ED attendances among 13–25-year-olds recorded as being due to an assault by a sharp object in England and the number of emergency admissions (among 13–25-year-olds) recorded as being due to an assault by a sharp object in Wales (respectively). For England these are broken down by age (13-17 and 18-25 years); for Wales, numbers were too small to do this. These were accessed via a FOI request in both England and Wales. In Wales it was not possible to access ED data on attendances with sharp force injuries due to the nature of ED medical coding, therefore admissions are presented.

Figure 5-7 Number of ED attendances among 13-25-year-olds recorded as being due to an assault by a sharp object in England

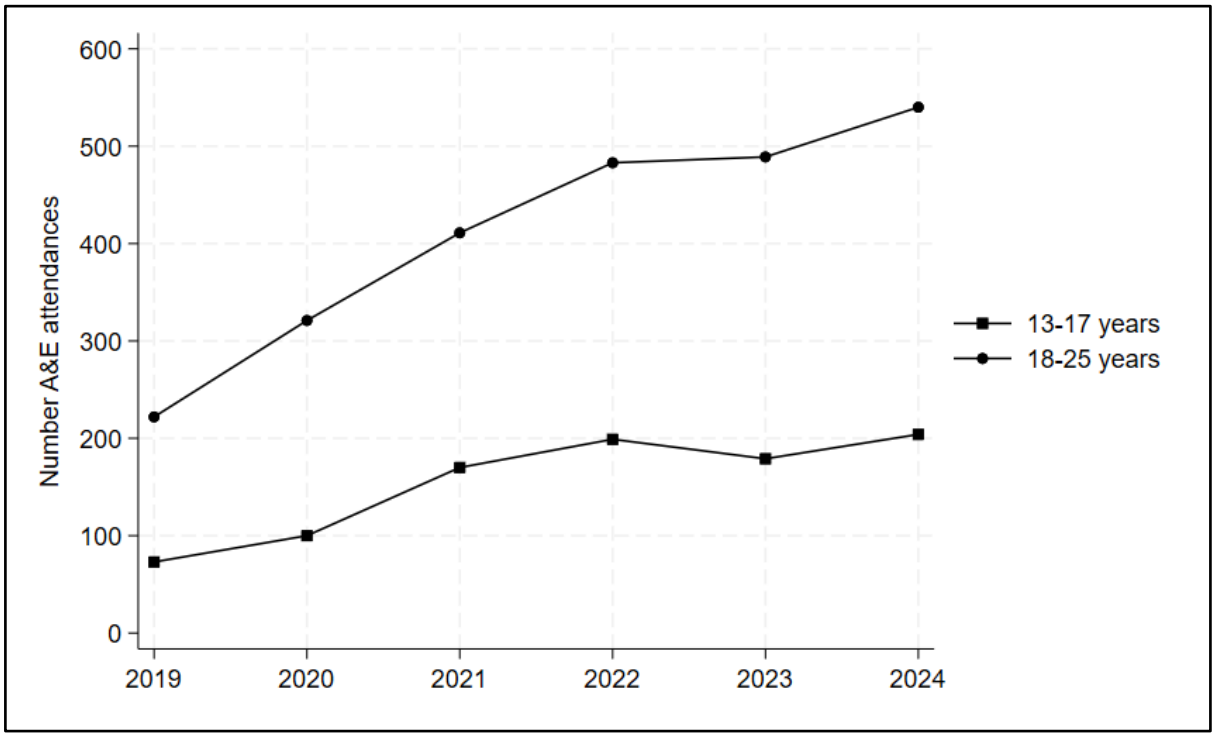
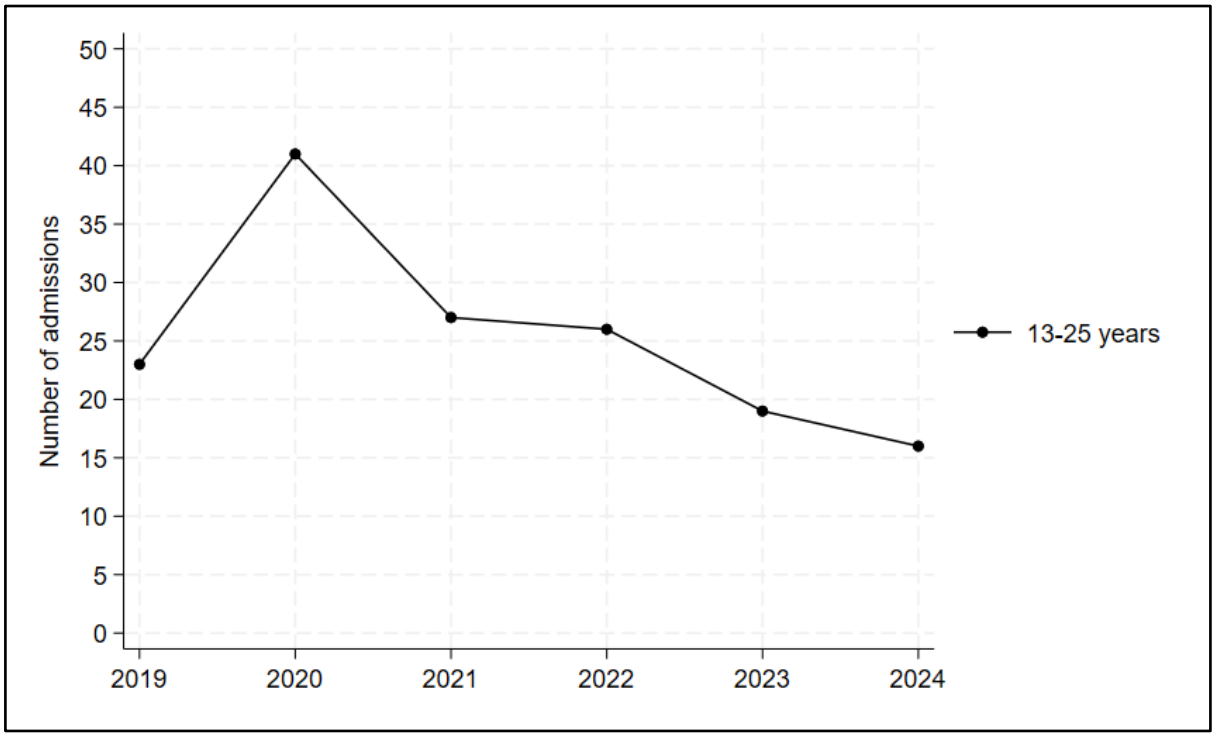


Figure 5-8 Number of ED admissions among 13-25-year-olds recorded as being due to an assault by a sharp object in Wales



Data were also provided broken down by NHS Trust (England) and local health board (Wales) but, for England, many of the numbers were suppressed for disclosure control purposes and the numbers for Wales were too small to present, so these figures are not included in this report.

These trends present a conflicting picture of increasing A&E attendances in England after an assault by a sharp object but decreasing admissions in Wales for the same presentation. However, there are significant limitations to the data presented in these figures and we do not believe these numbers accurately portray the reality of the number of patients presenting to hospital with knife or sharp object related injuries. We anticipate, in both cases, the numbers are likely far higher. To identify patients who have been assaulted with a sharp object, a patient record should be flagged as "injury related" and needs to have a relevant valid value in both the INJURY INTENT and INJURY MECHANISM fields. In practice, these two fields are often left blank. For example, as part of the data provided within the FOI request, of approximately the 7.3 million records in 2023-24 that were flagged as injury related, only 23% had both a valid INJURY INTENT and INJURY MECHANISM. In 2020-21 the figure was 22%. This clearly demonstrates the challenges of interpretating routine injury data, and we would strongly argue that figures 4.7 and 4.8 are unlikely to represent reality.

5.7.2. Prospective Survey

As reported in section 4.6, the mean number of patients seen per year was of 306.1 per site, equating to 0.84 clients per day.

9795 referrals to 32 A&E Navigator services are far higher than the total number of injuries by sharp objects in England reported in figure 4.8. This can be explained by several factors.

1) As outlined above, the FOI request is likely to be an under-estimate of presentations with injuries relayed to assault with a sharp object due to coding and under-reporting issues
2) The number of patients seen by A+E Navigator services, will be higher than the number of CYP presenting with injuries related to sharp objects, as services are referred CYP for other non-sharp object injury assault related issues
3) The response rate to this question was 64% of completed surveys. This will have resulted in reporting bias, as a third of sites did not report data. Nonresponders could be sites with low referral numbers, thus artificially inflating the mean number of CYP seen by site.

To understand the true scale of either assault by sharp object or the number of referrals to A&E Navigator services further detailed research on this question is required. To report the number of CYP who have been assaulted by a sharp object a prospective observational research project is required. To understand the volume of referrals to A&E Navigator services, any data should be broken down by referral reason (if possible) to better understand the nuance of why CYP are being referred to their service.

5.7.3. Focus groups and interviews

This question is addressed through the geospatial mapping exercise and the quantitative data, and not a question that could be directly answered through the focus groups, interviews or prospective survey.

5.8. To what extent do CYP with violence-related injuries have access to A&E Navigators in A&E?

5.8.1. Mapping

Figure 4.1 above outlines the availability of services according to geographical location in England and Wales. There was complete unavailability within the East Midlands, East of England, Southwest of England and Mid and North Wales.

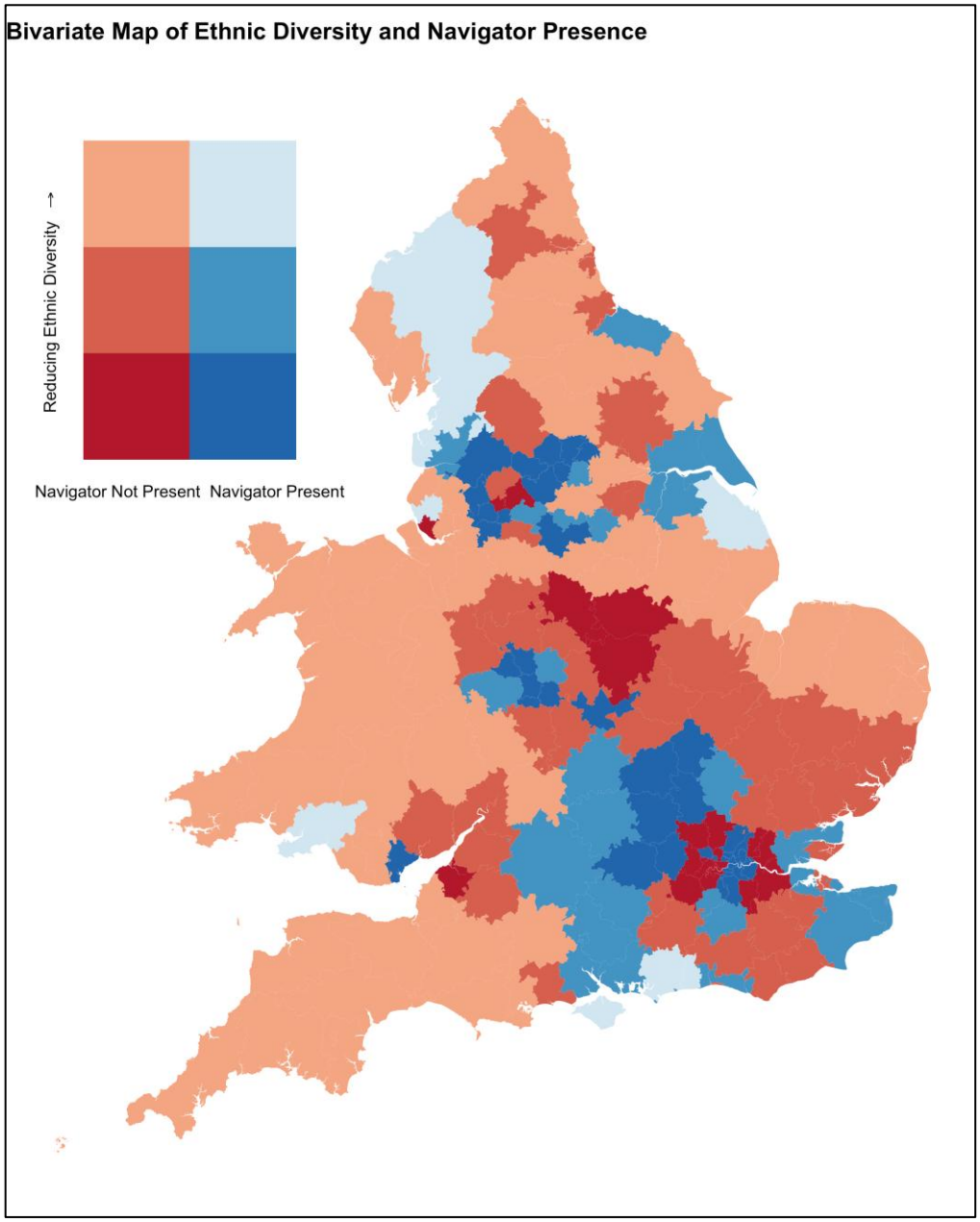
The London mapping shows very strong availability throughout the different regions of London, equally areas of the West Midlands, the Northwest and Northeast appear to have consistent availability across hospitals.

Overall, children and young people from minority ethnic backgrounds are more likely to have access to A&E navigator services. (Figure 4.9). Following the same statistical methodology as Section 4.3, for every 1% higher percentage of local population of White ethnicity, the

likelihood of A&E Navigator availability in the ED reduced by 6% (95% Confidence Intervals 4-9%). [3]

[3] Areas that are high crime are often seen as synonymous with a high proportion of ethnic minorities. The fact that there is a higher A&E navigator presence in these areas means more services are being offered to minoritised communities, which can be a good thing, provided this is done with race equity principles in mind e.g. representation of staff, effective community engagement, efforts to build trust with communities. The mere presence of services does not mean equitable implementation. There is also the risk of framing deprived racialised communities as more dangerous, rather than structurally unequal / neglected. So an effective race equity approach means making clear more crime is the result of more racialisation, criminalisation and deprivation - this is key to avoid reproducing stigma and encouraging co-production with communities.

Figure 5-9 Map of Ethnic Diversity and A&E Navigator presence in England and Wales



This mapping demonstrates geographical availability. The survey results below outline the day-to-day availability of services.

5.8.2. Prospective Survey - Days of the week

Of the 49 services who responded to the survey, figures 4.10 and 4.11 demonstrate the days of the week services are available for. This clearly shows services have excellent availability between Monday and Friday, however, cover at the weekends drops significantly. Only 30% of services have availability on Saturdays and 26% on Sundays.

Figure 5-10 Availability of A&E Navigator service by day of the week

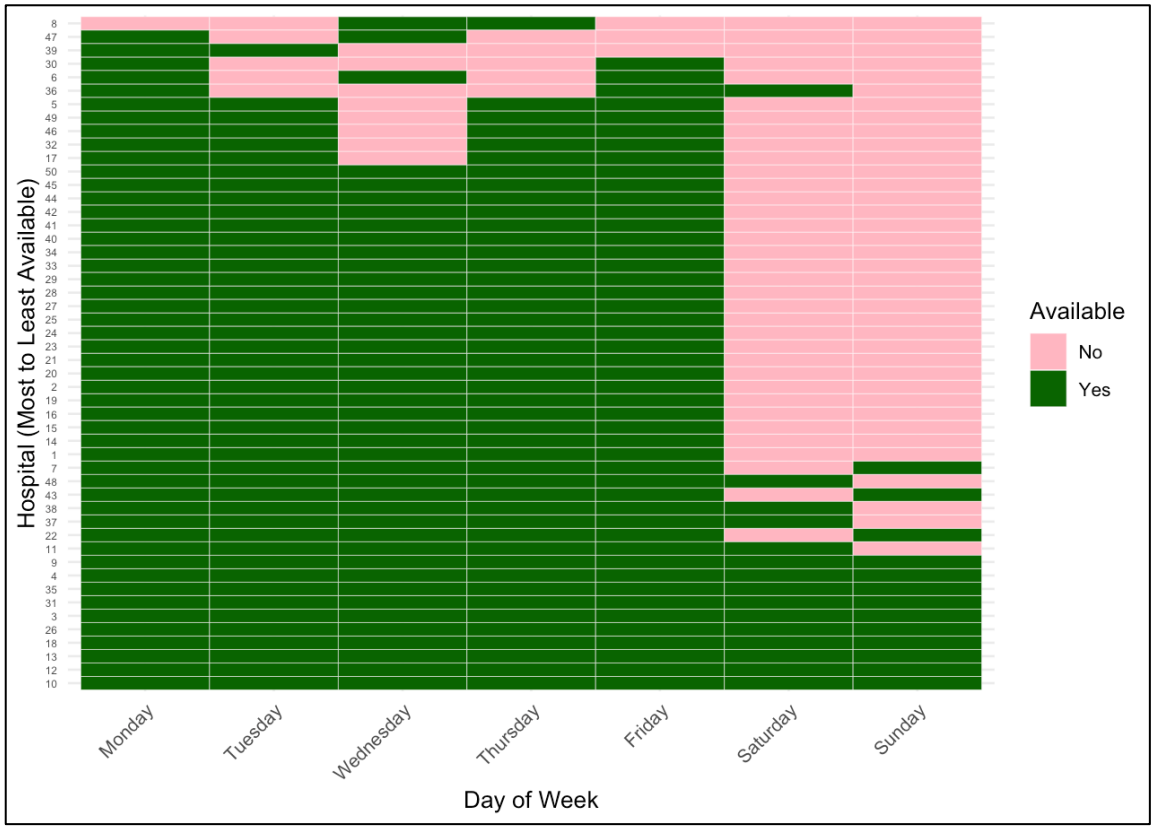
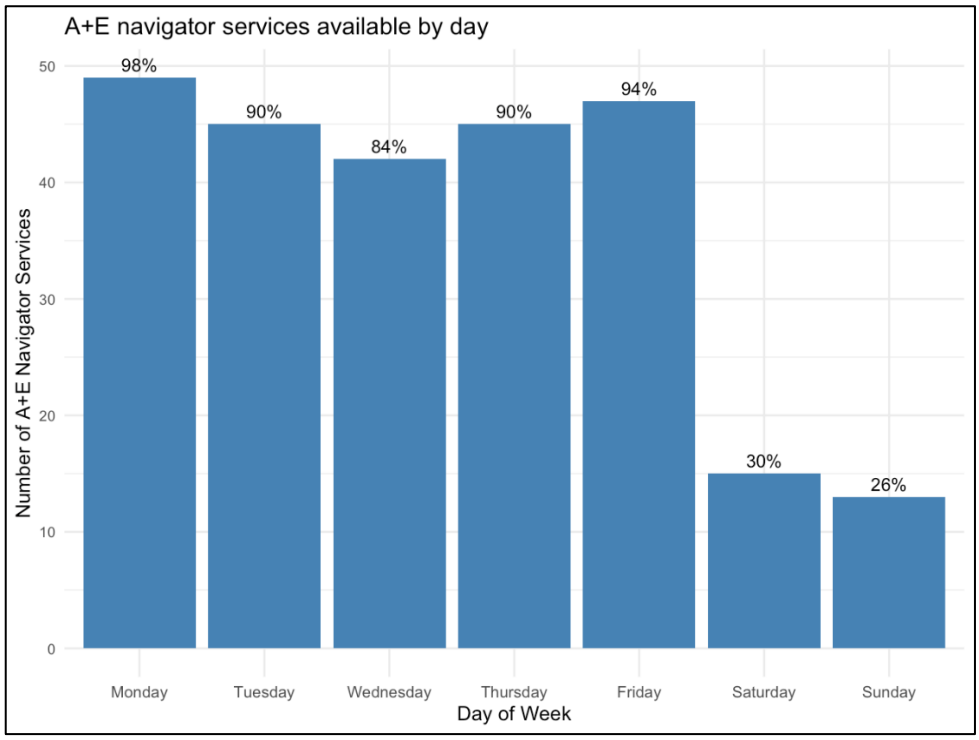
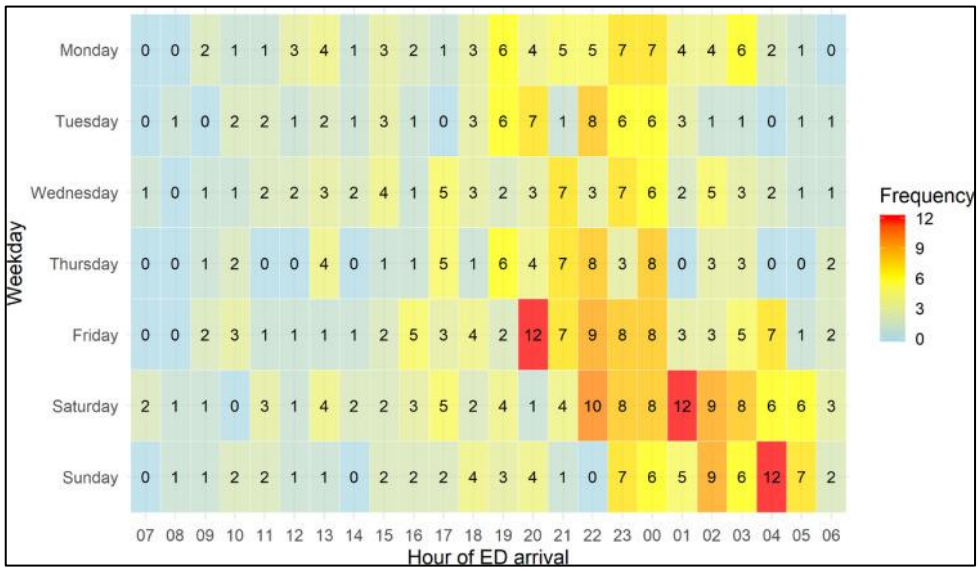


Figure 5-11 Total number of A&E Navigator services by day of the week



The availability of services is despite evidence that CYP presenting with violence tend to present out of hours (Figure 9.1). (15)

Figure 9.1 Times and days of presentation with violence related injury (figure republished under Creative Commons CC-BY-BC-ND license (15))



5.8.3. Times of day

The times of day that each service was available varied. Table 4.6 below outlines the availability patterns of services by morning, afternoon, evening and night. It is important to note, that whilst services were not necessarily available in the ED 24/7, many services continue to accept referrals and act on them upon their return to work in the following days.

Four services described a more flexible model, responsive to the needs of the local populations they serve. For example, one service responded with the following:

"…. we look at events that are taking place in our local area and amend our shifts accordingly to be present in the emergency department on those days."

Table 5-6 Times of day services available

Number of services running weekday and weekend (n=15), one service provided no data.				
Weekday				
Morning 0600-1200	**Afternoon 1200-1800**	**Evening 1800-0000**	**Night 0000-0600**	**Variable**
8	10	7	0	4
Weekend				
Morning 0600-1200	**Afternoon 1200-1800**	**Evening 1800-0000**	**Night 0000-0600**	**Variable**
6	10	8	0	4
Servies running weekday only n=27, one service provided no data)				
Weekday				
Morning 0600-1200	**Afternoon 1200-1800**	**Evening 1800-0000**	**Night 0000-0600**	**Variable**
19	26	15	0	0

In summary, no services are available at night (defined as midnight till 0600). Those services who offer a weekend service (n=15) offer very similar availability to their weekday patterns.

Services running a weekday service tend to offer a 9-to-5 availability, however 55.5% (n=15/27) offer cover into the evening.

5.8.4. Sex of CYP presenting to A+E Navigator services

Navigator services were asked to report the sex of CYP who had been referred to their service between April 2024 and March 2025. Fifteen services responded with complete data. Of the 4907 CYP referred to their service, 59.4% (2917) were reported as Male, meaning 40.6% of all referrals were for Female CYP.

5.8.5. Focus groups and interviews

Focus groups and interviews also provided some valuable insights into the practice considerations informing A&E Navigator access in the ED. For example, participants consistently distinguished between A&E Navigator access in ED, and A&E Navigator access by inpatients on hospital wards. Despite the title of the role- "A&E Navigator"- Navigators are not always located in the ED, and for those that are there is considerable variation in the amount of time spent there and the perceived purpose of doing so. While not an exhaustive list, the following are some of the considerations informing A&E Navigator time spent in the ED, and therefore the likelihood of young people having access to them there.

5.8.6. Perceived value of time spent in the ED

Time spent waiting in the ED for CYP with injuries to present is inherently unpredictable, with the potential for long periods of time spent without seeing anyone. Hospital data can provide valuable insight on common trends, but these are patterns rather than offering absolute certainty of CYP with serious violence injuries presenting. The volume of presentations at some sites is considered too low and too unpredictable to warrant the investment of significant A&E Navigator time in the ED. As one HCP and A&E Navigator lead noted:

"People are not, will not be managing…victims of…life threatening interpersonal violence, day in, day out…shift after shift...the prevalence you know may well be higher but it it's still…a small percentage of…emergency department work" (P13, HCP).

This issue is further complicated by considerations in relation to staffing contracts and the costs associated with A&E Navigators undertaking regular night and evening work.

5.8.7. Staffing contracts and working arrangements

Across sites staffing contracts and working arrangements present challenges in relation to the ability of A&E Navigators to provide effective access to young people in the ED. At one level these challenges revolve around the difficulty of getting started with the job, for example the time taken to set up honorary contracts can mean A&E Navigators are employed but unable to fulfil their role fully. Honorary contracts are important because they facilitate a range of

bureaucratic, organisational and information sharing arrangements, without which it is very difficult for Navigators to fully embed themselves within the hospital setting. As noted previously, A&E Navigators are commonly employed on 9-5 Monday to Friday contracts, meaning they are unable to be present in the ED at times when CYP with injuries related to violence are most likely to present. Navigators reported the challenges this can present, but also their willingness (to greater and lesser extents) to work flexibly with the contractual boundaries of their working day to prioritise contact with young people when it was most needed.

5.8.8. Hospital staff turnover

For A&E Navigator time in the ED to be most effective they need to be known to ED staff. With the high turnover of staff in many EDs this can be a challenging task, requiring a consistent effort to re-orientate new staff to the A&E Navigator service. One service, for example, reported that an important function of their weekly time spent in the ED was about being seen by staff and getting to know staff to improve referrals to the service. Navigators may, therefore, be spending time in ED but young people's access to them will be hindered if ED staff don't know about the Navigator service, or the referral criteria or process.

5.8.9. Boundaries of violence-related injuries

There are a broad range of injuries that might constitute a violence related injury. For example, victims of gender-based violence can be less visible or emphasised within wider narratives on serious youth violence emphasising gang, gun and knife related violent incidents. They may also need more specialist support that the A&E Navigators may not be able to provide without specific training e.g. training in the use of the Domestic Abuse, Stalking, Harassment and Honour-based abuse Risk Identification Checklist (DASH RIC), or referral to Multi-Agency Risk Assessment Conferences (MARAC) or Sexual Assault Referral Centres (SARCS). Beyond this distinction, there is much discussion within and across A&E Navigator services on how best to boundary the range of violence-related injuries A&E Navigators work with. For example, consideration may be given to whether self-directed violence (16) or risk-taking behaviours such as substance use should be included in the remit of an A&E Navigator service with the understanding that harm to the CYP is likely to result. These discussions inform important aspects of service delivery such as triage, assessment and referral criteria, and they have very real implications for who does and does not receive support from A&E Navigators.

5.9. How much of A&E Navigators' time is spent supporting CYP with violence-related injuries (vs supporting adults or CYP hospitalised for other reasons)?

5.9.1. Literature review

Our review of the literature revealed that CYP supported by the majority of A&E Navigator programmes present with violence-related injuries or are considered at risk of involvement in violence. However, some programmes do additionally provide support for other complex vulnerabilities such as exploitation, mental health crises or substance misuse (17, 18).

EDs represent a key point of contact for young people who have been involved in violence. Hospital based violence interventions such as A&E Navigators aim to use this contact point for its potential for 'reachable' (19) and 'teachable' (20) moments; times when CYP may be motivated to re-evaluate their circumstances and when they might be more open to intervention. The ED does undoubtedly represent an opportunity to 'reach' CYP whom may not normally come to the attention of services and who attend at moments of crisis as a result of violence. However, the 'teachable moment' which has become a popular concept in this situation is still open to debate in terms of the potential to prevent violence and there is, as yet, little robust evidence to support its efficacy (21).

5.9.2. Prospective Survey

The survey was not designed to gain a detailed report of how A&E Navigators allocate time to different patient groups, however, the types of patients referred to the services was collected.

Figure 4.12 reports that over 95% of A&E Navigator services offer support for violence related injuries, however many services offer a wider range of support for a myriad of social concerns including drug and alcohol issues and homelessness. Importantly services are accepting referrals for CYP presenting with a sexual violence related injury, decreasing the siloing of violence.

Figure 5-12 Type of patients referred to A&E Navigator services

Services Offered	Number of Services	% of Respondents
Young people presenting with a physical violence related injury	48	96
Other social vulnerabilities	35	70
Young people presenting with a sexual violence related injury	33	66
Domestic violence and abuse related issues	27	54
Anyone presenting with a physical violence related injury	27	54
Drug related issues	26	52
Alcohol related issues	24	48
Homelessness	18	36
Anyone presenting with a sexual violence related injury	16	32
No referral criteria selected	0	0

The survey could not breakdown the time commitments that each service spends on each type of presentation. The time commitment allocated to each group of referrals is likely dictated by the number of referrals received. The focus groups and interview data below explores this in more detail.

5.9.3. Focus groups and interviews

While originally designed to support CYP with a narrower set of violence-related injuries, there was evidence across case study sites that the A&E Navigator role has expanded- more significantly in some sites than in others. As is evident in figure 4.12, across A&E Navigator services Navigators now address a wide range of issues including mental health, substance misuse, sexual exploitation, and family breakdown. This evolution in the scope of these services could be said to reflect both the complexity of CYP'S lives (and their experiences of violence) and the gaps in existing services. As one A&E Navigator noted:

"I got on board that it was just the youth violence. But then slowly but surely realising actually it's bigger than just the youth violence" (P9, A&E Navigator).

Alongside discussing the complexity of violence and its inter-connections with other related issues, all services we spoke to across the 5 interview sites acknowledged that there simply wasn't enough work to solely focus on young people presenting with a narrower definition of "serious youth violence". However, discussions also suggested that once the scope of the role is broadened, services tend to experience a steep increase in demand and referrals. For some

services where they are funded to work only in the ED, they noted that CYP with serious injuries are transferred from ED (or other hospitals) to the surgical ward, prior to review by a Navigator, making it difficult to provide any input. For example, those CYP who need to go straight to surgery from ED or those transferred from a Trauma Unit to a Major Trauma Centre. Furthermore, where young people arrive with a police escort this presents additional challenges for A&E Navigator engagement (see later for further discussion on this). These barriers can mean the support in some contexts is more likely to be provided to CYP with less serious injuries.

A consistent theme is the importance of building trust and offering continuity of care. This often involves A&E Navigators providing long-term, flexible support that extends beyond the hospital setting, engaging with families, schools, and communities. These extended contacts are viewed by some services as important in revealing experiences of 'hidden violence', which might include experiences of domestic violence, sexual violence or criminal exploitation. At some sites, individual A&E Navigators worked flexibility across these alternative settings, but more commonly, services developed specialisms to focus on different facets of the issue (e.g. a school-based service, an outreach/community service or a parent service).

This wider conception of violence prevention work is reflective of an emphasis on a relational approach as being essential for effective intervention, particularly in cases involving more complex issues such as deep trauma or exploitation. While projects are clear about their core remit to focus on serious youth violence, A&E Navigators are typically afforded a high degree of flexibility to determine the nature of the issue that might warrant them working with a young person, and the period needed to work with that young person.

Returning to the research question, interview data suggest that the majority of A&E Navigators' time across a typical week is not spent supporting and in direct contact with CYP with SYV-related injuries. Across the interviews there was an emphasis on understanding and supporting CYP with injuries that might point to a risk of exposure to SYV, without always being directly violence related. Beyond this distinction, a significant proportion of A&E Navigator time was also taken up with activities seen as essential to the provision of effective support, such as building and maintaining professional relationships with medical staff, promoting the A&E Navigator service, liaising with referral partners and support agencies outside the hospital, and liaising with and supporting families.

5.10. Does the demand and uptake of A&E Navigator programmes vary by location or hospital type?

5.10.1. Mapping

All major hospitals in England and Wales have an ED. However, with established Regional Trauma Networks in England and Wales, the type of hospital a CYP with an injury can present to will be different. These hospitals are:

- **Major Trauma Centres**: These hospitals handle severe and complex injuries, often with patients being transferred from around the region to receive care. A&E Navigators in these settings often deal with high-acuity cases and provide intensive support.
- **Paediatric Major Trauma Hospitals**: Specialized children's hospitals focus on paediatric care. A&E Navigators here are trained to address the unique needs of younger patients and their families.
- **Trauma Units**: These hospitals treat a wide range of injuries and illnesses, and A&E Navigators provide support to CYP admitted with violence-related injuries. If injuries are severe, patients may be transferred to a regional MTC

These diverse settings potentially allow A&E Navigators to reach a wide range of young people, providing tailored support based on the specific context and needs of each hospital.

We've already commented on how A&E Navigator services are distributed in relation to IMD, crime and ethnicity (Section 4.3) and we hypothesize these measures may reflect local need. (Figures 4.3 to 4.6) We have shown that A&E Navigator services are present in areas of higher deprivation, crime and where there is a larger ethnic minority population. As outlined, it was not possible to use FOI data, or routinely reported injury data to accurately map or describe regional demand for services. The mapping work demonstrates there are certain regions without any services. These findings will have to be taken within the local context. For example, the East Midlands did have a service until its funding was cut in March 2024. (17)

When looking at the distribution of A&E Navigators in relation to hospital status i.e. whether a hospital is an MTC or not we can see that A&E Navigators services are available in two thirds of MTCs but only one third of TUs or local Emergency Hospitals (Table 4.7). What is unknown is whether services have been offered to other hospitals by funders but declined.

Table 5-7 Types of hospitals with A&E Navigator programmes

Country	Major trauma centres	Trauma Units/Local Emergency Hospitals
	Navigator present (n=Navigator/n=Total Sites) %)	Navigator present (n=Navigator/n=Total Sites) %)
England	18/26 (69.2%)	54/148(36.5%)
Wales**	1/1 (100%)	1/11 (9.1%)
Total	19/27 (70.4%)	55/159 (34.6%)
*The number of MTCs modelled differs from total number of MTCs in England due to overlapping catchment of paediatric specific MTCs ** In Wales there is only one MTC. Trauma services in North Wales are provided by University Hospital Stoke		

5.10.2. Prospective Survey

5.10.3. Uptake at hospital/regional level

To better understand the uptake up A&E Navigator programmes, it is useful to contextualise where funding for A&E Navigator services comes from. Table 4.8 outlines the number of services that receive funding from each of the sources listed. This shows that three quarters of services (76%) receive at least some of their funding from VRUs. To better understand how and why services are distributed in the manner they are, it is likely further work with VRUs is required to understand how they distribute and prioritise funding decisions across different hospitals and regio

Table 5-8 Source of funding for A&E Navigator services

Funder	Total (n)	%
Violence Reduction Unit	38	76
NHS	14	28
Other	14	28
Police	6	12
Charity	4	8

5.10.4. Uptake at ED level - numbers referred by hospital type

As reported above, the total number of CYP seen across the 32 services who reported data was 9795 over the last 12 months. This resulted in a mean number of CYP seen of 306.1 patients per site per year, equating to 0.84 CYP per day per site.

When this is broken down by hospital type (table 5.9), Adult MTCs see the highest mean number of CYP per site annually (411.1) and TUs see approximately two thirds of the amount, 278.7 CYP annually or 0.76 per day. The low number of paediatric MTCs reporting data, limit the interpretation of the low mean number of CYP seen at those sites. The daily volume of work at TUs remains high, 0.76 CYP per site per day, highlighting a demand for A&E Navigator services across all types of hospitals.

Table 5-9 Number of CYP seen by hospital type

Hospital Type	Responding Sites	Total Clients	Mean per Site per Year
Adult MTC	10	4111	411.1
Paediatric MTC	2	110	55.0
Trauma Unit	20	5574	278.7
Total	32	9795	306.1

5.10.5. Focus groups and interviews

As evidenced in the A&E Navigator mapping exercise, while services have expanded around the country, there remains considerable variation in where they are located and the short-term nature of their funding, combined with localised funding constraints, which can significantly impact young people's ability or willingness to access A&E Navigator services. Where CYP who may already have a lack of trust in services, for example, those in minority

ethnic groups, engage with a service only to see it withdrawn due to funding cuts this is only likely to reinforce their mistrust of services. Participants highlighted that service funding constraints can result in geographical location significantly affecting service availability and quality. For example, if a worker is funded to work with young people from a specific area, young people presenting with violence-related injuries from outside that area may not be offered a referral to the service- so there may be demand but not uptake. As one A&E Navigator noted:

"If you live in [Postcode 1], you can get the help… if you live in [Postcode 2], you're not going to" (P21, A&E Navigator).

Hospital size and complexity also play a significant role in shaping demand and update, with larger hospitals, particularly those serving urban populations, presenting potential mismatches between demand and staffing capacity. These staffing capacity issues hinge significantly on how broad the remit and referral criteria for the A&E Navigator service are set (as discussed previously). Excess demand can lead to backlogs and prioritisation of only the most high-risk cases, limiting the programme's reach and impact. The presence of A&E Navigator services in MTCs can mean they are better placed to engage with young people presenting with the most severe injuries but as noted previously, severity of injury and seriousness of violence involvement do not necessarily always align.

The expansion of the scope of A&E Navigator services in some locations beyond youth violence to include mental health, substance use, and social prescribing can enable services to more effectively reflect local needs, but it can also stretch resources thin. This expansion appears to be more feasible in hospitals with strong multi-agency networks and co-located services, highlighting the importance of local context.

The demand and uptake of A&E Navigator programmes are not uniform across the UK. Focus groups and interview data did not suggested that one hospital type was inherently more effective than another in achieving the best balance between demand and uptake, it largely depended on the practice approach and features of the hospital environment. For example, A&E Navigators at MTCs will see more young people with serious violence-related injuries but factors such the high intensity of medical needs, staff turnover and CYP being away from their home community may negatively impact uptake. Consideration of the interplay between demand and update, therefore, is shaped by a complex interplay of location-specific factors, hospital infrastructure, funding models, and the degree of integration within clinical systems.

5.11. What are the characteristics of hospitals that are more/less likely to benefit from A&E Navigator programmes?

5.11.1. Mapping

Hospitals in England and Wales are characterised by many criteria, including:

- Trauma status (MTC, TU, Local ED)
- The ages of patients they see (Mixed, Adult only, Paediatric only)
- Geography (urban, rural, coastal)

At the beginning of this chapter, we outlined an analysis of A&E Navigator presence by key characteristics, including deprivation, ethnicity, violence and crime rates (Tables 4.1-4.5 and Figures 4.3-4.6 and 4.10). It is likely that these social determinants of health are important characteristics that will determine the likelihood of benefit to patients with injuries related to violence. However, alongside that we need to consider the other hospital related factors above that might influence benefit such as those noted above, alongside the services the A&E Navigators provide. If A&E Navigator services were located only in MTCs and aligned only to serious violent injury several opportunities may be lost. Firstly, the wide area MTCs cover may make outreach work logistically difficult for A&E Navigator teams, restricting the number of CYP they could work with and limiting the community services they could link young people with. We also noted earlier that some have services have expanded their remit to include other social harms and that in doing this one commented that this allowed them to uncover 'hidden' forms of violence that may not have been the reason for admission. There is an argument that if A&E Navigators are placed only within MTCs opportunities to engage with CYP who might benefit from the service but may be less severely injured would be lost.

However, there is still a hypothesis that MTCs may be the best place to host A&E Navigators due to their exposure to the most severely injured patients, and in our analysis MTCs were significantly more likely than TUs to host A&E Navigator services. Our analysis does not have any evidence to support or refute the potential that MTCs are better placed to host A&E Navigator services. It is important to note that there remains significant demand for A&E Navigator services in TUs (table 4.9). Any move to shift further resources to MTCs only, will result in a significant unmet need in TUs. There is no UK based evidence to outline whether the severity of initial violence related injury, predicts future violence-based outcomes although one study in the US has shown that patients with gunshot injuries, which are generally severe injuries, do experience poorer outcomes and are twenty times more likely to be reinjured as a result of repeat violence than patients with non-violent injury

We have shown that hospitals with A&E Navigator services appear to be aligned with regions and catchment areas with high potential need, despite some areas of high potential need not having an available service.

5.11.2. Focus groups and interviews

Hospitals with strong and embedded multi-agency networks—where information sharing, joint assessments, and coordinated referrals are routine—are better positioned to benefit from A&E Navigator programmes. Weekly ED meetings, multi-disciplinary teams (MDTs) and shared systems with services like CAMHS (Child and Adolescent Mental Health Services) enhance the A&E Navigator's ability to act as a "cog in the machine".

Hospitals operating within systems that provide stable funding, integrated referral pathways, and access to patient data are more likely to sustain and scale A&E Navigator services. Conversely, those facing funding cuts, high staff turnover, and bureaucratic barriers struggle to maintain continuity. The issue of year-to-year funding decisions was consistently cited as presenting significant challenges in relation to the consistency of service delivery. As one lead staff member noted:

"We've had a reduction in funding year on year... we've lost staff that we've trained up" (FG2).

Hospitals most likely to benefit from A&E Navigator programmes are those with a supportive institutional culture, visible and valued A&E Navigator roles, strong interagency collaboration, strategic leadership, and systemic support (including strong community engagement and trust). These conditions enable A&E Navigators to build trust, coordinate care, and provide holistic, trauma-informed support to vulnerable CYP

6. How do CYP with violence-related injuries engage with available A&E Navigator programs?

6.1. Chapter Summary

This chapter explores the A&E Navigator process looking at how young people engage with the programmes and what factors influence engagement, participation and attrition. Importantly in this chapter we also explored whether programmes could engage meaningfully with CYP from minority ethnic communities and what factors impacted on their participation. To support that we considered the following questions and drew on information from different methodological elements of this study as well as the literature review.

- How long do CYP remain engaged with the programme, and with what intensity? (Section 5.2)
- What does participation involve, both in and beyond hospital? (Section 5.3)
- What factors/characteristics predict participation and attrition rates (e.g. age, severity of injury, length of stay in hospital)? (Section 5.4)
- Do participation and attrition rates vary according to CYP's ethnic background? (Section 5.5)
- How can programmes effectively engage CYP from minority ethnic communities? (Section 5.6)

Within the hospital setting, participation often begins at a moment of acute crisis, typically following a violent incident. CYP were referred to A&E Navigators from a range of sources. While most referrals were from ED staff, acute ward staff or a safeguarding lead or team, in some cases CYP self-referred or referrals came from family members. At other times A&E Navigators would proactively approach CYP in hospital.

We found that CYP were more likely to engage if the first contact with the service was face to face rather than by phone. Face to face contact seemed to significantly increase engagement and this was thought to be due to the increased opportunities to build trust with the CYP. However, at times, initial contact by phone was the only option, particularly if the CYP has been discharged and while less successful in terms of engagement, it was not always completely unsuccessful. Our literature review showed a wide range in variation in initial engagement with CYP over different sites from 17-88%. Those reflected the extremes, the majority of services reported engagement rates of between 34-75%. Several factors including hours of availability which again linked back to an element of phone contact may have influenced the lower engagement rates.

Once discharged from hospital the CYP could remain connected with the service in the majority of cases, only one service offered no outreach support. CYP could then receive

ongoing support from the A&E Navigator service or could be referred onto community-based partner organisations. This ongoing support reflected the flexible youth-centred engagement provided by the A&E Navigator services.

In terms of the process whereby A&E Navigators engage with CYP their work is always led by CYP and with their consent. Our research found an emphasis on a relational process which was flexible, youth-centred and informed by principles such as trauma-informed care, trust-building, and holistic support. Other important factors included the safety of the hospital environment which presented a unique setting and opportunity for disclosures, the importance of the A&E Navigators returning to visit the CYP again while in hospital and providing a consistent presence and the fact that they were not healthcare professionals and could have a different relationship with the CYP. A&E Navigators acknowledge that they often work beyond their formal role boundaries to provide support to CYP and their families and this was a consistent theme found in this study that emphasised the tensions between a formal service model or role description which can be quite prescriptive and what works in practice for CYP and for the service. Some services felt that their referral guidance (often restricted to in-hospital or emergency referral) limited their ability to build a trusting relationship with a young person, particularly if seriously injured, because the impact of such events may not be felt by them until sometime later.

A&E Navigators acknowledge the impact of structural issues such as long waiting lists, limited follow-up capacity, and inconsistent community links-which can impact on the participation of CYP. Again, here there was tension between policy-driven triage systems and the relational, trauma-informed ethos of A&E Navigator work. The A&E Navigators' perspective is that they are not always working with CYP who are 'ready to change' but rather those who are most seriously injured and the two can be mutually exclusive.

The type of support and length of support provided by different services varies considerably from emotional support through informal conversations, to more structured support programmes and from a one-off meeting in hospital to a longer engagement of up to 12 months. 15 sites provided engagement rates showing that over 60% of CYP engaged initially and that 80% of those CYP continued their engagement with the A&E Navigators beyond a first meeting.

50% of the services that responded were able, according to their guidelines, to provide support to CYP for over 6 months, however in practice most provided support for less than 6 months. There was an emphasis within most services on navigating CYP towards community supports, freeing the A&E Navigators to take on more referrals. However, most services were flexible and would leave the door open for CYP to contact the service again should they need to.

Factors from our research that seem to be key in maintaining engagement were the importance of building trust with the CYP, parental involvement which may influence participation either positively or negatively and developmental readiness, as opposed to chronological age.

Disengagement, however, was common according to the literature at around 30-50% and was most likely for those CYP reported as 'low risk'. In addition to this a variety of other factors predicted attrition including the CYP not being in education, employment or training, contact issues, chaotic lifestyles and mistrust of services. The transition from hospital to community seemed to be a key drop off point. The severity of injury could act both as a catalyst and barrier to engagement with the impact of serious injuries often not being felt immediately. From our prospective survey the most common reason for disengagement (84%) is the involvement of other services in the CYP's life. A quarter of services (24%) report that CYP being from a different geographical area also a key reason emphasising the importance of fostering good relations with local community partners.

Taken together all of these predictive factors relating to engagement and attrition demonstrate the importance of providing the opportunity for not just one, but multiple reachable moments or opportunities to engage and the value of long term follow up which was lacking in most of the reports and testimonies from the A&E Navigator services, many of which have only been running for a short time or have time bounded evaluations. Within recruitment practices it was also seen as useful for have some A&E Navigators with lived experience of violence as this helped facilitate communication with CYP and discussions based on experience, however, it was clear that this should be seen as only one component of their abilities alongside the other knowledge and skills they bring to the role.

It was a challenge to ascertain whether A&E Navigator programmes can successfully engage with CYP from minority ethnic backgrounds either from the literature or from our own research due to inconsistencies in recording of these data. While 84% of services reported that they collected information on the ethnic background of CYP and 24% reported disparities in engagement or outcomes for racially diverse CYP incomplete data collection made these figures difficult to interpret overall. Only 50% collected data that would allow identification of any disparities in relation to race equity which might allow for improvement. Most services had no policy on how their service might interact with police officers who might accompany a CYP to hospital in order to facilitate a safe space for the CYP, something particularly important for CYP from racially diverse backgrounds who can be both adulted and assumed to be involved in violence because of their race (22).

A complex interplay of cultural factors such as stigma around seeking help, particularly for mental health, structural inequalities such as systemic racism and unconscious bias, and interpersonal factors such as language barriers (78% of services had access to translation

services) and family involvement seem to influence the engagement of minority ethnic CYP. There was also general acknowledgement from services of the broader intersectional impact of socioeconomic inequality on CYP from minority ethnic backgrounds which needed to be afforded attention. With regard to intersectionality for this group tailored interventions that consider culture alongside family participation and commination are seen as potentially more effective at ensuring engagement and for this group it was seen as being vital that the wider family were supportive and involved. This was particularly true where CYP from ethnic minority backgrounds were struggling with their mental health something which in some minority ethnic communities is still viewed with a degree of stigma (23, 24).

While the infrastructure of many services included policies and procedures outlining their approach to racial equity most focussed on staff recruitment. The issue of representation within A&E Navigator teams was highlighted as a key issue, cultural competence and inclusive recruitment strategies were seen as important to avoid unconscious bias. A&E Navigators also acknowledged that they needed to be willing to challenge unconscious bias both within themselves and their organisations.

6.2. How do CYP with violence-related injuries engage with available A&E Navigator programs?

It is important to understand the process by which CYP engage with A&E Navigator programmes and the rates at which they engage as this will inform future service improvement. Data for this primary question is taken from the literature review, survey, focus groups and interviews.

Overall, from the literature, initial engagement with A&E Navigator services varied widely between 17% (25) and 88% (26) taking up the initial offer of support. Ten of the other programmes reported engagement rates of between 34 and 75% and six programmes did not report participation rates. Considerable variation in engagement was also seen between hospitals supported by the same service with one service reporting 72% engagement in one of their hospitals and just 28% in another (27) and this was also noted in another service where there was 75% engagement in one hospital and 50% in another (28). The author of the paper of the site with the lowest engagement rate of 17% suggested this may be because this hospital was not a major trauma centre (25), something suggested by reports from another hospital site (29), however, it should be noted that the site with the highest engagement rate was not a major trauma centre (26). It seems more likely that possible reasons for very low engagement were that this was a programme targeted specifically at gang related violence so perhaps suffered from stringent referral criteria; it was also staffed by youth workers who exclusively worked during normal business hours and required CYP to participate in a 12-session programme which may have been off-putting for some- it was noted that of those who did participate only 18% completed all 12 sessions.

Of 50 A&E Navigators sites surveyed, 15 provided engagement rates for their service. These demonstrated that 60% of CYP engaged with those services initially and 80% of those CYP continued their engagement with the A&E Navigators beyond a first meeting. Almost all A&E Navigator services receive referrals from both safeguarding/child protection teams and ED clinical staff. This suggests the services that responded to the survey are well integrated within hospital teams responsible for CYP who are experiencing violence. (Table. 5.1)

Table 6-1 Referral sources to A&E Navigator programmes

Referral Source	Number of navigator services	%
Referral from safe guarding or child protection team	49	98
Referral from Emergency Department (A+E) staff	48	96
We pro-actively speak to potential clients or young people if we feel it may be appropriate	39	78
Self referral from potential clients or young people	22	44
Other	16	32
Referral from the family of potential clients or young people	14	28

The fact that almost 80% of services pro-actively approach CYP within hospitals, demonstrates a level of autonomy within the clinical environment, again supporting the idea that A&E Navigator teams who responded have the relevant access, contracts and agreements to work within clinical spaces.

A&E Navigators approach CYP in a multitude of different clinical and non-clinical environments (Table 5.2) including community environments such as schools (62%). Many services (88%) have the capacity to approach CYP by phone after discharge. Whilst this is an efficient mechanism to contact CYP, especially if they present at times when A&E Navigators are not present (see section 4.8.2), there are questions over the effectiveness of telephone only contact to suitably engage CYP. One service reported that patients approached in person by the A&E Navigators and asked to participate in a programme were twice as likely to do so as those contacted by phone. (28)

Table 6-2 Where are CYP approached by services?

Where can CYP be approached	Number of navigator services	%
Whilst still in the Emergency Department (A+E)	48	96
On the hospital wards if admitted into hospital	45	90
By telephone once they go home	44	88
Arrange to meet at client or young person's home/school/other personal environment	31	62
A meeting place run by our Navigator service	16	32
Other	2	4

6.3. What does participation involve, both in and beyond hospital?

Literature review

A&E Navigators provide support to CYP while in hospital, in the form of both emotional, and practical support with a wide range of issues including housing, travel, clothing, safety planning and support to help CYP understand their medical treatment. Some services also provide counselling. One programme offers a 12-session mentoring programme. (25) All organisations continue their support on discharge and work with the CYP to connect them with appropriate community-based organisations and services. Community support provided by the A&E Navigators themselves can take the form of signposting to other organisations, advocacy, mentoring and attendance with the CYP at services and community groups. The form this support takes is often guided by the CYP. (30)

6.3.1. Prospective Survey

The majority of services offer a holistic service whilst the CYP is in hospital supporting the individual (94%) and families (78%) through liaison with clinical (94%) and social care (96%) staff, including work with educational establishments (84%) (Table 5.3).

Table 6-3 Support offered in hospital

Support offered in hospital	Number of services	%
Liaison with social care staff	48	96
Emotional support for the individual	47	94
Liaison with medical/clinical staff	47	94
Rapid referrals to agencies that can respond to ongoing threats to a child's safety	45	90
Liaison with school or other educational establishment	42	84
Emotional support for the family	39	78

Support for CYP extends out of hospital (Table 5.4) and includes a wide range of different types of support including for substance misuse (92%), housing (78%) and employment (74%). Many services offer mentorship either directly (80%) or via referral (76%). The broad range of services offered via referral and ongoing multi-agency collaboration (90%) suggest a high

degree of integration with community services and the ability to support many different aspects of a CYP's life.

Table 6-4 Support offered to CYP out of hospital

Support offered out of hospital	Number of services	%
Substance misuse services through referral	46	92
Ongoing multi-agency collaboration	45	90
Mentoring with your service	40	80
Housing support through referral	39	78
Mentoring through referral	38	76
Employment support through referral	37	74
Community violence reduction services through referral	37	74
Psychological therapy through referral	35	70
Sports or arts programmes through referral	35	70
Social and emotional skills programmes through referral	34	68
Employment support through your service	30	60
Housing support through your service	27	54
Social and emotional skills programmes through your service	26	52
Community violence reduction services through your service	18	36
Sports or arts programmes through your service	9	18
Substance misuse services through your service	7	14
We do not support after hospital discharge	4	8
Psychological therapy with your service	3	6

6.3.2. Focus group and interviews

The focus groups and interview data places a heavy emphasis on a relational process underpinning many A&E Navigators work with CYP. This commonly extends well beyond the initial point of contact in EDs. Participation in A&E Navigator services is not a one-size-fits-all

model but rather a flexible, youth-centred engagement informed by principles such as trauma-informed care, trust-building, and holistic support.

Within the hospital setting, participation often begins at a moment of acute crisis, typically following a violent incident. As indicated in the survey data, the first contact with a CYP in the hospital might be in the ED or at the point that they are admitted to a ward. There is variability across A&E Navigator services in the time and resource invested in initiating a first contact with CYP in either of these settings.

The language of “reachable/teachable moment” is commonly used to describe this contact in a moment of crisis, yet it is also seen as both an opportunity and a challenge. Some practitioners question the immediate post-trauma timing for engagement, preferring to emphasise the significance of multiple "reachable moments". Regardless of the perspective on this concept, all emphasise the importance of a consistent and empathetic presence, whether in the ED or on the ward. A&E Navigators often make multiple visits to build rapport, recognising that trust may take time to establish. The hospital environment provides a unique space for first disclosures, where young people may feel safe enough to share experiences of violence or trauma for the first time. Across the range of professionals interviewed, value was placed on the ability of A&E Navigators to open conversations with young people that are difficult for other professionals to have. As one A&E Navigator noted:

“[We] get to walk in in plain clothes and are experts in talking to young people about what's happening with their lives.” (P27, HCP).

While the initial contact for some CYP will be by phone, accounts from A&E Navigators suggested face-to-face contact is critical at this stage. Participants, across all stakeholder groups highlighted the value of “putting a face to the person,” which fosters trust and humanizes the support process. A&E Navigators are often perceived as non-clinical, relatable figures- “not wagging their finger”- which helps break down barriers between young people and formal services.

Participation also extends well beyond hospital walls, encompassing a wide range of community-based and relational activities. Indeed, as noted above, the first point of contact for A&E Navigators can often be a phone call to a young person after a referral from a HCP. A&E Navigators adapt their approach to meet young people where they are- literally and figuratively. For a variety of reasons, CYP may be fearful, hesitant and distrusting at the first point of contact, so A&E Navigators try to work at a pace that is dictated by the CYP. This can be particularly challenging when negotiating competing demands, such as high caseloads, referral deadlines or resource limitations.

Contacts outside the hospital might involve meeting in schools, homes, parks, or even fast-food restaurants. The flexibility in location, timing, and method of contact (e.g., phone calls, e-mail, informal chats) is central to maintaining engagement. Within some services A&E Navigators work flexibly across the hospital and wider community settings (see table 6.4 for overview of out of hospital support offered across services). Other services have developed specialisms, with some A&E Navigators focusing their time primarily in the hospital and others focusing their time in community settings. This points to an emerging innovation or evolution in the A&E Navigator role where, for some A&E Navigators, the hospital no longer acts as the first point of contact.

Support provided by A&E Navigators is consent-based and youth-led, with CYP empowered to decide the nature and extent of their involvement, however, there is some variation across services in how consent is interpreted and operationalised, for example whether consent is written or verbal and how and where this is recorded. The specifics of how consent is navigated is heavily informed by what form the first point of contact takes, i.e. in-person, over the phone, in the ED or on ward, referral or non-referral.

For those young people who do engage with A&E Navigators, the nature of support varies considerably. Some opt for emotional support through informal conversations, while others engage in more structured support, such as goal setting or referrals to mental health, education, or employment services. All A&E Navigator services report having a “maximum” or “target” period of contact for working with a CYP, by which time they would look to have achieved a ‘positive outcome’ from their contact, where ‘positive outcome’ is typically determined by funding criteria and operational goal setting criteria. Across services, however, there is variation in what this maximum period is set at, and A&E Navigators themselves commonly emphasise remaining engaged with a young person:

‘*until we feel it’s the right time to leave’* (P9, A&E Navigator),

emphasizing continuity and responsiveness to individual needs over working to an arbitrary deadline.

As noted previously, participation commonly has a strong relational dimension to it. A&E Navigators invest significant emotional labour, often going beyond formal role boundaries to support young people and their families. This includes whole-family support packages, advocacy in schools, and navigating complex referral systems. The emotional toll on staff is acknowledged, with resilience and peer support seen as essential to sustaining this work. The question of family support is one we will return to again, as it is commonly cited as an important aspect of the A&E Navigator role.

Despite the commitment of A&E Navigators, and those working with and alongside them, systemic barriers- such as long waitlists, limited follow-up capacity, and inconsistent community links- can hinder sustained participation. There can also be tension between policy-driven triage systems and the relational, trauma-informed ethos of A&E Navigator work. As one HCP noted:

"We set the triage system more to manage waiting lists... rather than managing people with behavioural readiness to change." (P5, HCP).

There is something of a chicken and egg situation at play here. It is difficult to understand a CYP's 'readiness to change' before building a relationship with them, which triage systems are not designed to do. Triage systems may, therefore, end up referring based on criteria, such as seriousness of injury, which aren't necessarily the best indicators of seriousness of violence involvement or readiness to change. Nonetheless, the adaptability and persistence of A&E Navigators often mitigate these challenges, enabling meaningful engagement even in the face of structural constraints. Participation in A&E Navigator services is a fluid, relational process that (most typically) begins in hospital but unfolds across multiple areas of a young person's life. A&E Navigators consistently emphasised the significance of initial contact, and on-going engagement, that is characterized by empathy, flexibility, and a commitment to empowering young people on their own terms, albeit that some aspects of the service delivery context and processes can aggravate against their ability to fulfil this aspiration.

6.4. How long do CYP remain engaged with the programme, and with what intensity?

6.4.1. Literature review

Overall, from the literature, young people remained engaged with services for variable lengths of time ranging from engagement only while in hospital (26) to up to 12 months (31). Some programmes e.g. Redthread's programmes in Birmingham and Nottingham supported CYP for a prescribed length of time, generally 12 weeks, although there was some flexibility built in (18, 32).

6.4.2. Prospective Survey

Of the 50 sites, 15 sites provided data on the number of referrals they received (table 5.5). They also provided data outlining how many of these referrals resulted in a first meeting between the CYP and the A&E Navigator service. Finally, they reported the numbers of CYP who engaged beyond a first meeting. For some CYP, the drop off between the first meeting to ongoing engagement, may reflect no further input required or a loss to follow-up.

Table 6-5 Engagement after referral

Sites (n)	Total clients (n)	Engaged for 1st meeting (n)	Engaged beyond 1st meeting (n)	Engaged for 1st meeting (%)	Engaged after 1st meeting (%)
15	5729	3532	2839	61.7	80.4

All 50 services reported how long they can support young people for within their service model (table 5.6). Over half (58%, n=29/50) were able to support greater than 6 months and only one service offered an in-hospital service only.

Table 6-6 Length of time of support services can offer

Engagement Duration	Number of Services	%
We can support for over a year	22	44
We can support for between one and three months	11	22
We can support for between six months and one year	7	14
We can support for between one week and one month	5	10
We can support for up to a week	2	4
We can support for between three and six months	2	4
We do not support after hospital discharge	1	2

Services were asked, in practice typically, how long they supported CYP for. The length of time support was provided to CYP varies considerably but the single most common duration of support was between six months to one year (n=18, 36%). Most services (n=31, 62%) provided support of less than 6 months with only 1 service providing support to CYP for over a year. (Table 5 .7).

Table 6-7 Length of time services tend to support for

The length of time we tend to support for	Number of Services	%
We typically support for between six months and one year	18	36
We typically support for between one and three months	14	28
We typically support for between three and six months	11	22
We typically support for between one week and one month	3	6
We typically support for up to a week	2	4
We typically support for over a year	1	2
NA	1	2

Many services have the capacity to support for over a year (Table 5.6) but only one service typically does this (Table 5.7). While good practice guidance exists nationally on the period of time A&E Navigators should work with CYP (33), there is variation across and within services in relation to the length of time that services should support a CYP for. As the interviews highlighted (see section below), decisions about when support should stop is often CYP dependent. However, enabling a safe and timely handover to other community teams, including education or employment services, should be planned within the service and with the CYP to allow for capacity for new referrals coming through and to manage expectations of the CYP.

6.4.3. Focus groups and interviews

The engagement of CYP with A&E Navigator programmes is shaped by many of the factors discussed in the previous sections, including (but not limited to): severity of injury, context of first point of contact, personal circumstances, family engagement and service delivery priorities.

The need for a limited engagement period is typically driven by resource limitations and the need to prioritise high-risk cases, noting that most A&E Navigator services report working to referral criteria that encompass a range of violence and violence-related issues. However, A&E Navigators report that their service's stated engagement period can often be insufficient to meet the needs of young people, particularly given time needed to build trust, to understand the wider context of the CYP's circumstances and, for some, the delayed emotional responses that often follow traumatic incidents. As one lead staff noted:

"Six weeks is the official thing... but the young people will cling to you if you let them" (P4, Lead Staff).

This highlights the tension between policy and practice, where emotional bonds and ongoing needs often extend beyond the formal engagement window.

As with the length of engagement, the intensity of engagement varies significantly, often depending on the severity of the CYP's situation and the capacity of the service. Some interactions are described as deeply immersive and emotionally intense, with one A&E Navigator recalling:

"It was the most intense kind of interaction I've ever done… I was with him for nearly four hours" (P12, Parent).

This suggests that while some engagements are brief and targeted, the level of intensity can still be significant. Anecdotally, these short encounters at a 'reachable' or 'teachable' moment', can provide effective long-term change for CYP. However, this is an area that requires further study to understand which CYP, and under what situations, benefits can be gained through these shorter but more intensive interventions. These encounters also raise important considerations in relation to A&E Navigators' readiness for the intensity of the role, which we will return to later.

While some services report working with CYP for up to a year, this is less common, and engagement tends to be over a shorter timeframe with an emphasis on navigating CYP into contact with services capable of providing longer term support. Where A&E Navigators did talk about working with CYP for longer periods of time, their accounts suggested services didn't always have the systems or evaluation processes in place to capture the outcomes of these longer-term engagements. The absence of longer-term check-ins or systems to track outcomes over time can impact continuity, risk disengagement and limit the ability to assess long-term impact.

Despite formal time limits, many services talk about adopting an open-door policy, allowing CYP to return for support as needed. This model acknowledges the previously discussed non-linear nature of recovery and the importance of maintaining trust:

"*They can come back to us if they want to. So, there's always an open door with us*." (P22, Lead Staff).

Returning to the research question, while formal guidelines often suggest a limited engagement period as reflected in Table 5.7, actual practice reveals a more nuanced and flexible approach adopted by A&E Navigators often informed by an emphasis on relational continuity.

6.5. What factors/characteristics predict participation and attrition rates (e.g. age, severity of injury, length of stay in hospital)?

6.5.1. Literature review

Our review demonstrated that A&E Navigator delivery models exhibit some variation which can make them difficult to compare. For example, in relation to the age range of CYP the presenting issues and support needs for those presenting at the extremes of these age ranges are likely to be very different. Of the 18 reports, 14 show that available programmes support CYP aged between 10 and 25 years of age (e.g.(29, 30, 34)), one supports CYP as young as 8 years of age (31), the remainder work with young people who are under 18 years of age (26, 32) and one programme works with a range of age groups from 11-35 years of age. (35)

Disengagement with A&E Navigator programmes is common at around 30-50%. Most sites did not gather quantitative data on the reasons for disengagement after initial contact but qualitative date showed that many young people disengaged shortly after discharge, particularly when contact was initiated via phone rather than in person. (28)

Some CYP declined support after initial agreement, while others were lost to follow-up, had given incorrect contact details or declined ongoing contact. One service reported this applied to 66% of CYP offered the service. (36)

Individuals viewed as 'low-risk' were more likely to disengage, as were those who did not perceive themselves to need help (29) or who were already engaged with other services e.g. CAMHS (37). Other issues that seemed to predict attrition included CYP not in education employment or training, difficulties in maintaining contact (37), chaotic lifestyles and mistrust of services due to experiences of marginalisation (34). A key factor also noted in several publications was not having made initial face to face contact with the CYP and hence being unable to quickly establish a trusted relationship with them (26, 28). The transition from hospital to community-based support was often a critical drop-off point. (36)

Although not specifically highlighted in any publications, we should consider whether disengagement when passing CYP onto services may reflect difficulties such as language barriers or a lack of trust in services if, for example, CYP from minority ethnic backgrounds do not view services as being culturally relatable.

6.5.2. Prospective Survey

The reasons for non-engagement of CYP in A&E Navigator services are reported in table 5.8. It is important to note that these reasons are provided by services and not CYP. It is reasonable to assume the reasons listed in table 5.8 could be different from the perspective of CYP.

Table 6-8 Reasons for non-engagement

Reason for non-engagement	Number of services	%
They have multiple other services involved in their lives	42	84
They do not give an obvious reason why they do not want to engage	29	58
Mistrust of health care professionals or the navigator service	21	42
They are scared	21	42
Peer pressure not to engage	21	42
Family pressure not to engage	21	42
They are in hospital for too short a period to build a rapport	18	36
They do not understand that the navigator service is different to the healthcare they are receiving	15	30
They are not from the area and did not want to engage with someone away from their home	12	24
Other	11	22

The most common reason for non-engagement (84%) is due to the involvement of other services in the CYP's life. A quarter of services (24%) report CYP being from a different geographical area as another key reason. This highlights the need for services to have protocols in place to liaise with youth, health and social services from other regions. This phenomenon could represent patients being transported away from their local area for clinical reasons (i.e. transfer to a MTC) or due to issues with criminal exploitation and county lines. Each of these scenarios would require different responses from the A&E Navigator service.

6.5.3. Focus groups and interviews

As discussed in the previous section, a consistent theme across the data is the centrality of trust and rapport in predicting sustained engagement. A&E Navigators emphasized the importance of empathy, persistence, and emotional intelligence in building relationships with young people, particularly those who are initially resistant or disengaged. Repeated ward visits and informal, non-clinical interactions were often necessary before a young person would begin to engage meaningfully. To highlight the time-intensive nature of trust-building one A&E Navigator noted:

"It's been like 5 or 6 times we've seen them before they've even really engaged in conversation" (P3, A&E Navigator).

Age emerged as a nuanced factor. While younger patients may be more open to support, their younger age means that parental involvement and gatekeeping will influence their

participation, although A&E Navigators typically emphasised the role of parents in encouraging engagement. Conversely, older CYP may have more entrenched behaviours or mistrust of services, but also greater agency in choosing to engage. The data suggest that developmental readiness- rather than age alone- is a more accurate predictor of participation.

The severity of injury, particularly in cases involving life-threatening violence, can act as both a catalyst and a barrier to engagement. The vulnerability of such an experience may prompt some CYP to engage with an A&E Navigator and make disclosures that they might not have previously disclosed. Others, however, may experience a delayed trauma response and/or be fearful or mistrustful of police involvement, which may make them less likely to engage in the immediate aftermath of such an experience (see further discussion on this in chapter 7) This delay underscores the previously discussed emphasis on multiple reachable moments, and the value of long-term follow-up, currently lacking in many services. As a parent of a young person impacted by a life-threatening violent incident reflected:

"It's the days and weeks afterwards that it really starts to hit home what's happened to them" (P14, Parent).

Longer hospital stays provide more opportunities for A&E Navigators to build rapport and introduce services, while short stays or rapid discharges can limit this window, increasing the risk of attrition. Flexible models that allow A&E Navigators to follow up post-discharge are therefore a critical component of an A&E Navigator approach that aims to minimise attrition rates. It is worth re-emphasising the point here that the severity of harm (commonly aligned with length of stay) is not necessarily correlated with the seriousness of the CYP's involvement in violence. As one experienced emergency consultant interviewed suggested:

"*There is no correlation whatsoever between severity of injury and need for admission, and future risk*" (P27, HCP).

This quote is not presented as evidence of the absence of a correlation, rather to illustrate a point made by a number of participants questioning any *assumed* link between severity of injury and future risk. A range of socioeconomic and environmental factors were cited as underlying factors affecting both participation and attrition, these included: disadvantage, educational exclusion, housing instability, and exposure to gang violence or county lines. As one A&E Navigator noted:

"They feel like they've got no other choice... it's an easy way to make money." (CS1P1).

These contextual factors can either motivate engagement (as a way out) or hinder it (due to competing priorities). Wider contextual factors also shape the service offered to the CYP, with service fragmentation, postcode lotteries, and funding constraints also impacting attrition. Inconsistent availability of services across regions means that some CYP can fall through the cracks, through the absence of a service to engage with.

6.6. Do participation and attrition rates vary according to CYP's ethnic background?

6.6.1. Literature review

Within the available literature several services recorded the ethnic background of the CYP they supported and, with the exception of London where there was a very mixed ethnic picture, (37) most other services that recorded ethnicity seemed to support mainly White CYP (26, 38).

The recording of ethnicity appears to be a consistent challenge and one that makes it difficult to discern whether these programmes can effectively engage CYP from minority ethnic communities. Parkinson *et al* reporting on the A&E Navigator service in West Yorkshire noted the ethnic group was either not recorded or unknown for 15% of the patients they supported. (38) The overwhelming majority of patients they reported supporting were White and while this may be an overrepresentation due to recording disparities the authors also note that this may also indicate that young people from the White ethnic groups may feel more comfortable accessing support, implying that Black and ethnic minority groups may not. Another study in East Midlands reported that 34% of CYP were from non-White British backgrounds and concluded that demographic factors did not affect the chances of engagement, however, ethnicity was not recorded for 38% of the patient cohort meaning that these conclusions were drawn from an incomplete sample. (18).

A point highlighted within the literature was the importance of an A&E Navigator service being relatable. Trust in a service and an individual A&E Navigator as a support will likely be improved if CYP are presented with someone who not only shares their experience but who looks like them and who they identify with culturally. (29) This was mentioned by the A&E Navigator service in Wales who, even though most of their patients were White, could see the potential benefit of a more ethnically diverse workforce. (28)

Stigma has also been reported as a contributing factor to attrition generally. (26) Some CYP are reluctant to be associated with services perceived to be linked with social services or authorities, which can deter ongoing engagement. Intersectionality undoubtedly has a role to play here. We should be mindful of the dual role of state, on one hand funding public health approaches to violence prevention such as A&E Navigators through VRUs, and, on the other hand perpetuating racialised harm via the criminal justice system, social care and healthcare inequalities. This can also be magnified by the connections the VRUs have with the police. Taken together these factors can serve to increase mistrust in state commissioned services such as A&E Navigators among minoritised communities and so these services need to work to acknowledge these tensions and address them openly.

Feelings of embarrassment, distrust of professionals, or fear of being judged may cause any CYP to step back after initial interest (34) but these issues may be magnified for CYP from

marginalised groups. The perception and association of risk of involvement in violence may be increased for CYP from Black and ethnic minority backgrounds who are disproportionately represented in the criminal justice system at all levels including stop and search, arrest and conviction.(3) Most CYP involved in violence whether as victims or perpetrators are White and the perception that Black and minority ethnic CYP are more likely to be involved in violence serves to reinforce pre-existing broader structural inequalities.

Some CYP, particularly those from some minority ethnic groups, may feel unable to accept support from an A&E Navigator of the opposite gender and for those CYP this additional impact of intersectionality may reinforce the inequality they already face. Services therefore need to be prepared to be flexible and culturally sensitive when offering support.

6.6.2. Prospective Survey

As the number of services reporting detailed referral and engagement rates was low (30%, n=15/50), we have not collected detailed data on the specific participation or attrition rates by service for CYP from minority ethnic backgrounds. However, we have collected data on A&E Navigator services organisational approach to race equity. These results are listed below.

The majority (86%) of A&E Navigator services collect ethnicity data (Table 5.9). However, seven services collected no ethnicity data at all which demonstrates that standardised data collection methods can still be improved.

A quarter (24%) of A&E Navigators services observed disparities in the engagement or outcome for racially diverse individuals with violence related injuries (Table 5.10). Of note 30% of services did not respond to this question. This highlights the need to better collect data on engagement and outcomes, including the effect of key characteristics like ethnicity and race.

Table 6-9 Outcomes measured by each A&E Navigator service

Description	Count	Percent
Gender of the patient assessed and supported	49	98
Age of the patient assessed and supported	48	96
Referrals to your service that were made and followed up	48	96
Ethnicity of the patient assessed and supported	43	86
Referrals that were declined	43	86
Interventions and support delivered	42	84
Length of patient's engagement in the programme	39	78
Trends in types of injuries	38	76
Time and day of the week of hospital/ED arrival	31	62
Hospital/emergency department attendance rates	23	46
Other (please specify)	15	30
Length of stay in hospital/ED	8	16

Table 6-10 Has your service observed any disparities in the engagement or outcomes for racially diverse individuals presenting with violence-related injuries?

Response	Number of services	%
Yes	12	24
No	23	46
Missing	15	30

6.6.3. Focus groups and interviews

The quantitative data speaks more directly to measures in the variability of participation and attrition rates on the basis of ethnic background. However, the qualitative date also provides

some useful contextual considerations. Findings highlight a complex interplay of cultural, structural, and interpersonal factors that influence the engagement of CYP from minority ethnic communities. Services that maximise participation and minimise attrition require a multifaceted approach that addresses a range of related considerations, such as representation, cultural sensitivity, systemic inequities, and intersectionality.

Structural inequities, including systemic racism and unconscious bias, were identified as significant barriers to participation. Participants noted that assumptions about race and violence can lead to misrepresentation and under-engagement. One A&E Navigator reflected,

"*sometimes black young men might be viewed by healthcare professionals, maybe that they're kind of viewed as older than they are, or they present…If you're coming in because of violence related, it might be a high trauma. So, they're not talking, they can't talk*" (P28, A&E Navigator)

This highlights the need to challenge stereotypes and broaden understanding of vulnerability. Additionally, language barriers and cultural stigma around seeking help were cited as deterrents, particularly among communities such as the Traveller population and recent immigrants.

Participants emphasised that the relationship between race, ethnicity and participation/attrition cannot be considered in isolation. Intersectionality- particularly the overlap of race, class, and gender- was seen as critical to understanding engagement. Many participants argued that deprivation and lack of opportunity cut across ethnic lines, with one lead staff member noting,

"*It's more of a classism issue than a race issue... lack of opportunities, lack of money, lack of safe housing*" (P10, Lead Staff).

This suggests that while ethnic disproportionality exists and must be acknowledged and pro-actively addressed, effective engagement must also address broader socioeconomic vulnerabilities.

Engaging families and communities were seen as essential activities especially in overcoming generational and cultural resistance. Participants observed that parental attitudes often shape young people's willingness to engage, with one stating,

"*It's the adults that still need opening up and engaging with*" (P22, Lead Staff).

Participation and attrition rates are impacted by a complex interaction of inter-related factors. Understanding how these factors play out for any given child or group requires a contextualised understanding of that CYP or group's particular circumstances. This understanding can be challenging to achieve within a busy hospital context with competing demands and time constraints impacting staff-patient interactions. This points to the value of

a role with an orientation to, and time investment in, getting to know the young person. As one HCP noted in relation to A&E Navigators,

"They have an inordinate amount of patience... they come with an open mind" (P15, HCP).

This also places an important emphasis on ensuring the A&E Navigator is well embedded within the hospital systems and processes, so that the knowledge they gain can inform wider practice interventions with young people. The following section will look more closely at how programmes might more effectively engage CYP from minority ethnic communities.

6.7. How can programmes effectively engage CYP from minority ethnic communities?

6.7.1. `Prospective Survey

The survey did not collect specific data on engagement and attrition by ethnicity, but it did ask questions that explored the organisational approach to race equity. (Table 5.11)

Table 6-11 Do you have any policies outlining your organisational approach to race equity?

Response	Number of services	%
Yes	39	78
No	8	16
Missing	3	6

Table 5.11 shows that over three quarter of services (n=39, 78%) had policies which outlined their organisation approach to race equity. Of the 39 services that responded, 100% provided responses to a question outlining what the focus of these policies are (table 5.12)

Table 6-12 What areas do your race equity policies focus on?

Area	Number of services (n=39)	% of all 49 services
Recruitment	39	78
Engagement with potential clients of the service	37	74
Community engagement	32	64
Overarching strategy/vision	31	62
Advocacy	25	50

Table 5.12 demonstrates that all responding services have race equity policies which focus on staff recruitment and 95% (n=37/39) of services have policies outlining engagement with potential patients. However, in terms of active data collection, only 50% (n=25/50) of services report collecting ethnicity data that would allow an understanding of disparities in engagement or outcomes (Table 5.13)

Table 6-13 Do you collect and analyse data on the race and ethnicity of individuals presenting with violence-related injuries to identify any disparities in engagement or outcomes with your Navigator service?

Response	Number of services	%
Yes	25	50
No	22	44
Missing	3	6

In terms of day-to-day operations table 5.14 and 5.15 outline whether A&E Navigators have a policy about how they should deal with police when they are present in the ED and access to translation services.

Table 6-14 Do you have a policy which outlines how A&E Navigators deal with police when they are accompanying the potential client?

Response	Number of services	%
Yes	11	22
No	38	76
Missing	1	2

Table 5.14 demonstrate that three quarters (76%) of A&E Navigator services do not have an active policy about their interaction with police and by inference therefore no policy that supports the engagement of minoritised CYP with A&E Navigator services when the police are present. The balance between a patient's right to confidentiality and the safety of the public in cases of serious youth violence is a challenging area, with specific General Medical Council Guidance in place to help Doctors in this situation. (39)

Balancing the need to treat and build a rapport with a patient and support the police in their investigations is really challenging. Due to significant concerns regarding trust in the police from CYP, it is important that A&E Navigator services have a considered policy about how they

interact with the police to maximise the support they can deliver to CYP, whilst ensuring the safety of the public.

Table 6-15 Do you have access to language translation services?

Response	Number of services	%
Yes	39	78
No	11	22

Access to translation services appears to be good, with over three quarter of services (78%) reporting the availability of language translation services (Table 5.15). Whilst for most this will be in the form of telephone translation service, some services highlighted the benefit of employing bilingual A&E Navigators who can both translate and have a local understanding of the cultural barriers experienced by CYP who do not have English as a first language.

In terms of outreach into communities to better understand the root cause of violence, half of services (50%) report doing this (Table 5.16). This is the same number of services who report undertaking advocacy as part of their race equity policies (Table 5.12).

Table 6-16 Does the A&E Navigator program collaborate with community organisations and leaders from racially diverse backgrounds to better understand the root causes of violence-related injuries within specific communities and tailor the services accordingly?

Response	Number of services	%
Yes	25	50
No	17	34
Missing	8	16

6.7.2. Focus groups and interviews

Many of the discussion points explored in this section pick up on threads opened in the previous section, although the emphasis here is towards offering actionable insights for programme design and delivery. The importance of trust-building is a recurring theme, particularly in communities where historical and systemic mistrust of institutions exists. Participants emphasized the need for empathy, kindness, and confidentiality in interactions with CYP. This highlights an important role for A&E Navigators in advocating for young people in instances when their involvement in a violent incident may present challenges for some

professionals in seeing them first and foremost as a victim. One A&E Navigator emphasised this in discussing her role as an advocate for young people,

"*no matter what he's done in this moment, while he's walked through these doors or brought him through, he's a victim"* (CS5P1).

The absence of cultural understanding can engender mistrust amongst CYP and hinder meaningful engagement. The issue of representation within A&E Navigator teams was highlighted as one, but not the only or even primary, consideration in relation to building trust and engaging young people. Some A&E Navigators, for example, report considering patient characteristics, including ethnicity, when assessing if they are the best person to make an initial contact with a young person. Importantly, this consideration extends beyond ethnicity to include characteristics such as gender, class and lived experience. The suggestion is not that A&E Navigators can or should only engage with young people from similar backgrounds to them, rather it is to emphasise the importance of a range of measures - including but not limited to - diversity in recruitment strategies and the value of prioritizing cultural competence within A&E Navigator teams, and more widely within hospitals. Cultural competence training and inclusive recruitment strategies were emphasised as an important component in ensuring staff can navigate cultural nuances and avoid unconscious bias.

Participants acknowledged that engagement challenges often stem from broader systemic issues, including racial disproportionality, language barriers, and cultural stigma around mental health. These barriers are compounded by socioeconomic deprivation, which was frequently cited as a more unifying factor than race alone. A&E Navigators with lived experience of violence or adversity were seen as particularly effective in connecting with young people. Their ability to share authentic stories helped break down barriers and foster trust. As one A&E Navigator shared,

"*It's good to be able to tell that story and have them know it's not some scripted nonsense*" (P8, A&E Navigator)

There was, however, also an emphasis on not defining A&E Navigators with lived experience by their lived experience, or assuming that this is all they can or should offer within a service. Staff with lived experience (recognising this is not limited to A&E Navigators) should be viewed for the breadth of knowledge skills and attributes they bring to a professional role and invested in accordingly.

The research underscored the importance of recognising intersectionality- how race, class, gender, and other identities intersect to shape young people's experiences. By implication, services that adopted a one-size-fits-all approach are limited in their ability to acknowledge and work with the full intersectional diversity of the young people they engage. Instead, tailored interventions that consider cultural background, family dynamics, and community context offer greater potential for fostering engagement.

Engaging families and communities was seen as essential, especially in building generational and cultural awareness. Participants observed that parental attitudes often shape young people's willingness to engage. Misunderstandings and stigma within families- particularly around mental health- could hinder engagement as ethnic minority communities may have institutional mistrust due to intergenerational trauma and racism in healthcare settings. Some A&E Navigators noted that they are often acting as advocates for children who are misunderstood by their own parents who originate from countries and cultures where issues they are facing are not recognised, for instance LGBTQI* identities and with mental health challenges. Supporting CYP who are second-generation migrants to communicate with the elders in their communities was cited as an important role that is often overlooked.

School-based outreach and community partnerships were recommended as strategies to build trust and awareness, and to bridge generational and cultural gaps. This links to a broader emphasis on the significance of community outreach and community-based initiatives for effective A&E Navigator engagement. As one A&E Navigator noted:

'*the education side was just that link that we were seeing all the time with young people that were coming through who had either been excluded from school, had some issues or some negative experiences with education*[i]' (P7, A&E Navigator).

Finally, a strong organisational commitment to equity, inclusion, and ongoing training was seen as foundational. A&E Navigators must be equipped to challenge bias- both within themselves and among other professionals. As one A&E Navigator put it,

"*I will challenge everybody... I'm always the uncomfortable person in the room*" (P26, A&E Navigator).

This A&E Navigator demonstrates her commitment to calling out and challenging inequity and discrimination, but staff burnout could easily result if such challenge is left to motivated individuals and if those individuals find themselves having to work against organisational cultures, systems and processes.

7. What are the key criteria for successful A&E Navigator programmes?

7.1. Chapter Summary

This chapter explores the distribution of A&E Navigator services in England and Wales and seeks to determine whether they are located according to local needs. To answer this, we also explored the following sub questions.

This chapter has three additional sub questions:

- What are the characteristics of an effective A&E Navigator? (Section 6.4)
- What challenges are experienced when implementing programmes and how can these be overcome? (Section 6.5)
- Are there specific models/examples of best practice that could be adopted more widely? (Section 6.6)

This report did not aim to define what a 'successful' A&E Navigator program is, or the outcomes from the perspective of a young person that define success. However, the research does allow us to outline what criteria allow an A&E Navigator service to establish themselves and then thrive within EDs. These criteria can be summarised as secure funding, A&E Navigator face to face availability, integration within EDs and community links.

As many of the A&E Navigator services have only been established within the last five years, these same themes are present within the existing literature.

78% of A&E Navigator sites included in this study were funded on a yearly basis with no guarantee of continued funding. The lack of stable funding is one of the most significant issues faced by these services and one which leads to feelings of insecurity among staff and contributes to staff turnover. The annual funding cycles are likely linked to the fact that most of these services are funded by VRUs which work with one year government budget and funding cycles and it is this rather than a lack of intention not to continue funding that dictates how this funding is deployed. However, we also observed that some services have had funding withdrawn despite positive evaluations.

From an operational point of view both the literature review and our interviews stressed the importance of meeting CYP face to face as this was important for building trust and the services that seemed to function well did this as much as possible or tried to work flexibly within the confines of their contracts. However, the working patterns of many A&E Navigator services meant that most were not available out of hours at times when CYP injured as a result of violence typically present to the ED.

Most services in our study were well integrated into the ED and worked well alongside their NHS partners, something they saw as being central to their ability to operate their service successfully. Also crucial was the capacity of a service to accept referrals and alongside the

hours of operation this was also linked with the numbers of staff member employed within each service. The majority of services (58%) employed between 2-4 staff but 10% employed only one. Two services within MTCs could only accept 0-3 referrals weekly due to limited capacity.

Successful programmes also fostered strong community links which gave them a referral pipeline for CYP to other services. In addition, it allowed them to understand the context and community the CYP lives in and to gain local knowledge.

Our research demonstrated the importance of the personal characteristics of individual A&E Navigators to the success of programmes. Their non-clinical status allowed them to transcend professional barriers which can exist between clinical staff and their patients and flatten any perceived hierarchy. A&E Navigators were viewed as being flexible, non-judgemental, trauma informed, person centred and collaborative. It was also noted that they needed to be people who could quickly build trust with both CYP and NHS staff. Many (32%) had a youth work background and some also had lived experience of some of the issues faced by the CYP.

A&E Navigator programmes do, however, face challenges both in relations to structural issues arising from their unique positions as external organisations within an NHS environment and in relation to their interactions with CYP. These challenges were evident both within our own work and in our review of the literature.

Within the NHS A&E Navigators faced challenges relating to a lack of sustainable funding limiting opportunities to build a sustainable service, lack of physical space to work in and poor integration into departments in some cases, this resulted in reduced visibility for teams which impacted on referrals. Due to the fact that ED teams are large and have a high turnover of particularly their resident doctors on rotation, A&E Navigator teams had to constantly spend time familiarising NHS staff with their service. In addition to this, and related to poor integration, some A&E Navigators did not have honorary contracts limiting their access to NHS systems. Finally, some the A&E Navigator services had complex referral pathways requiring a lot of information from the NHS staff which again limited referrals because NHS staff were so busy. Successful integration on both sides clearly rests on an appreciation of the roles of each party and a will to make working together as easy as possible. One A&E Navigator suggested a blueprint both for setting up these services and for delivering them would be helpful to save constantly having to reinvent ways of working together.

Our research found that in some cases the onward referral community pathways were not well established or agreed, this again was linked to funding precarity for some of these organisations who were not consistently able to provide a service. This has the potential to lead to backlogs in the system preventing A&E Navigators from taking on new referrals because they have no clear pathways for the CYP who are ready to move on, mirroring some of the issues seen within the EDs themselves.

In terms of interactions with CYP, and as was a theme throughout this report, building trusting relationships, establishing early face to face contact and a relational approach were seen as being key to the A&E Navigator's success in engagement. Integration into NHS teams was also seen as essential by clinicians alongside having committed teams of staff and consistent funding.

In terms of challenges in engagement the fact that some CYP had a lack of trust in services was a significant issue and building a relationship with these CYP took time which limited the capacity of the service. The role also took a huge emotional toll on the A&E Navigators because of the emotional investment required in some cases which can if left unnoticed lead to burnout. A&E Navigators have put in place local adaptations to mitigate some of these challenges such as implementing boundaried practice, development, training and support and work to improve integration, interagency working and collaboration.

Another challenge faced was 'defining violence'. Teams recognised that even if violence was not the initial presentation there were many associated factors that, where referral criteria were very strictly defined and limited to violence alone, could be missed and those issues were often associated with hidden forms of violence or other significant harms. This again relates to the way A&E Navigator services in England and Wales are funded and may point towards the need to involve other funders so that violence is not 'treated' in a silo.

At the end of this chapter, we have provided a profile of our 5 interview sites, and while these are not exemplars of best practice, they do demonstrate the range of working practices of these A&E Navigators sites and their view of their successes and challenges.

7.2. Literature review

7.2.1. Secure funding

In a review of services in Birmingham, short-term funding emerged as a major operational challenge, creating staff insecurity, difficulty recruiting and training teams, and reducing the capacity for sustained delivery. (32) This was supported by a further evaluation of services in Liverpool, in which a review noted that on the organisational side, fixed-term contracts, slow commissioning processes, and staff vacancies led to instability, delaying implementation and creating gaps in service coverage. The report stated that these challenges illustrate the need for longer-term funding, full integration into hospital teams, and flexible delivery models responsive to both clinical and community environments.(36)

7.2.2. Navigator face to face availability

It was also key that an A&E Navigator service has the ability to provide flexible, youth-led support (31, 32). In this regard face-to-face contact, particularly during a young person's hospital stay, was repeatedly identified as crucial for engagement. These direct conversations, often at the bedside or during emotionally vulnerable moments, created a powerful

foundation for trust. In several evaluations, it was noted that the ability to engage during this immediate crisis window was what made the difference between a CYP accepting or declining support (28, 29). The addition of specialist roles, such as in-house counsellors, provided by one staff member in the Redthread service in the Midlands also enhances the offer (29).Having a trained counsellor on the team seemed to facilitate keeping the CYP in a safe space while waiting for mental health assessment in the face of long waiting lists and also expedited their entry into a mental health pathway where required. Additionally, the counsellor was able to provide support to other team members to improve their practice with regard to mental health.

7.2.3. Integration within EDs

Embedding an A&E Navigator service within the ED was crucial to its success. Those with a permanent and dedicated base in the ED (36), consistent visibility in the ED, particularly during key hours of attendance for CYP (36), longer established teams who had sustained relationships with NHS staff who were supportive of them (29, 37) were significantly more effective (28-30). Clear and straightforward referral pathways facilitated the referral process for the busy ED staff and maintain frequent communication with clinical and safeguarding teams.

7.2.4. Community links

The success of A&E Navigator services also depended on the strength of their external partnerships; services that worked closely with community services and local agencies were better placed to deliver co-ordinated support and seamless referrals. In this way, Navigators served as bridges across systems, building meaningful relationships with young people, clinical teams, and community organisations alike (26, 37).

High-performing services prioritised training and supervision for their staff, including reflective practice, which enabled staff to manage the emotional demands of the work and adapt to the needs of the local population. Another core success factor is the co-design of the support offer with the CYP (30). Programmes that include the young person's voice in planning goals and shaping the style and pace of engagement reported saw stronger commitment from young people and the ability to offer more tailored interventions outcomes. The flexibility of the A&E Navigator's approach, meeting CYP where they are emotionally and practically, was key to this success.

7.3. Prospective Survey, Focus Groups and Interviews

As highlighted at the beginning of this section, these same four themes were echoed in our primary research.

7.3.1. Secure funding

78% of A&E Navigator sites have funding commitments for one further financial year only (Fig. 6.1). This lack of long-term sustainable funding is covered in-depth in section 6.5.2 below, but it is clear both through the survey and focus groups and interviews that funding is the biggest issues faced by A&E Navigator sites. We are aware of five sites that have lost funding since our research began in February 2025 (Appendix 2) and we know of a further programme based in Nottingham that ceased to provide a service in 2024. This was despite a positive evaluation report. (17)

Funding and sustainability issues were identified as critical in both the focus groups and interviews. Many services operate on short-term or year-on-year funding, leading to high staff turnover, service instability, and morale issues. One lead staff member noted,

"*We've had a reduction in funding year on year... we've lost staff that we've trained up*" (FG2).

This instability undermines the continuity and long-term planning necessary for effective service delivery. While none of the services offered a solution to this issue, those with the ability to diversify funding sources appear better positioned to buffer themselves from funding uncertainties.

7.3.2. Navigator face to face availability

The literature review strongly outlines the importance in face-to-face availability. In our interviews and focus groups, this theme was re-iterated with respondents stating:

"We've worked with young people on the ward... it's been like 5 or 6 times we've seen them before they've even really engaged in conversation" (P3, A&E Navigator)

Despite this emphasis, the prospective survey data demonstrates potential challenges to both the availability of services and the capacity of services to take on all referrals. The availability of A&E Navigator services by day and time was covered above in figures 4.11 and 4.12 and table 4.6. These data demonstrate that only a third of services are available at weekends and no services are available overnight. These are both times when young people with violence related injuries are more commonly known to attend EDs. (15) This will inevitably reduce the ability of services to provide that initial face to face contact.

7.3.3. Integration within EDs

Hospitals that value and integrate the A&E Navigator role into their clinical ecosystem appear more likely to benefit from the programme. Where A&E Navigators are seen as part of the team, their impact is amplified. Conversely, in hospitals where A&E Navigators are unfamiliar or undervalued, their effectiveness is diminished. This lack of recognition can lead to role

ambiguity and missed opportunities for engagement, especially in fast-paced ED environments. As one A&E Navigator noted:

*“We could go into A&E now and say we’re the Navigator service and some people would say ‘no idea’” (P*2, A&E Navigator).

Hospitals with dedicated space and visibility for A&E Navigators tend to foster better integration and service delivery. In contrast, limited physical presence can hinder their ability to build trust and engage effectively. As one A&E Navigator shared:

*"We were given a broom cupboard... we’ve never really carved an actual physical space out into the hospital” (*P11, Lead Staff).

This data is supported by findings from the survey, (Table 6.1), shows that over half of services are physically based in the ED. Of potential concern is the fact that almost a fifth (18%, n=9) of services are not based in the hospital at all. Information provided in the literature review, focus groups and interviews, would suggest direct availability and visibility within hospitals increases the likelihood of referrals to the service.

Table 7-1 Physical location of A&E Navigator service

Physical location of the navigator service	Number of services	%
In the Emergency Department (A+E)	26	52
In the hospital but more than 2 minutes walk away from the Emergency Department (A+E)	11	22
In the hospital but within a very short walk (less than 2 minutes) from the Emergency Department (A+E)	4	8
Not based in the hospital but attend the Emergency Department (A+E) when required	9	18

This highlights how physical marginalisation within hospital settings can reflect and reinforce institutional marginalisation. Hospitals with clinical champions and strategic leadership that bridge policy and practice are more likely to support sustainable A&E Navigator models. Flexibility in service design and responsiveness to local needs also emerged as critical. This adaptability allows services to respond to broader vulnerabilities beyond youth violence, such as mental health and trauma.

"Our model has rapidly evolved and changed... we worked between Commissioners and providers and clinical staff... to adapt and change" (P13, HCP).

7.3.4. The capacity to accept new referrals

The majority (70%, n=35/50) of A&E Navigator services have the capacity to take on seven or more referrals a week. Of note are the two Adult MTCs who only have the capacity for 0-3 referrals per week. Data from the numbers of referrals services receive suggests capacity should be around one referral per day, or seven referrals a week. However, the low referral capacity in certain settings may reflect more intensive, longer-term support being provided.

38 sites reported their capacity to take on new referrals. 14 services stated they lacked the capacity to take on new referrals. 3 sites were and adult and paediatric MTCs respectively and 8 were trauma units.

7.3.5. Community links

Whilst face to face presence within the ED is key to the success of A&E Navigators and the relationship built with young people, links back into the community are also a key part of the success of these programmes. This was supported by our survey results which demonstrates the large number of services with established links and referral pathways to community services. In table 6.4 over 90% of A&E navigator services report ongoing multi-agency collaboration out of hospital, as a key component of their delivery model.

From our Interviews and focus groups, as described in section 5.3, services report links with families, communities and education establishments as vital to building generational and cultural awareness. This allows A&E Navigators to be cognisant of the local challenges CYPs face and builds institutional knowledge of the structural inequities faced by the CYP who present with violence related injuries. This knowledge gives A&E Navigators the best chance of creating and maintaining relationships with CYP but also provides them with an understanding of which community resources will be best placed to support that CYP over the longer term.

7.4. What are the characteristics of an effective A&E Navigator?

7.4.1. Literature review

In terms of effectiveness, this seemed to depend on both individual factors particular to the A&E Navigators which seemed to be shared across services, and to operational factors associated with the services themselves which acted as facilitators for the A&E Navigator role which are discussed above.

Almost all studies agreed that effective A&E Navigators were flexible, non-judgemental, trauma informed, person centred and collaborative both in terms of their relationships with

NHS staff and with wider community organisations. In addition, they seemed to have the ability to build trusted relationships both with the CYP and the NHS staff in the ED. Two studies commented on the fact that unlike the ED staff, they were not clinical, and this was seen as a positive attribute for their role (18, 27).

7.4.2. Prospective Survey

The survey was not designed to answer whether or not services were effective, however, we can report the make-up of the work force and the funding arrangements for services.

Table 6.2 outlines how many A&E Navigators each service employs. The most frequently reported number was 2 A&E Navigators, reported by 28% of services. 10% of services employed only one A&E Navigator (n=5). When combined, just over three quarters of services employed between 1 and 4 A&E Navigators (68%, n=34/50)

Table 7-2 Number of Navigators employed per service

Number of A&E Navigators employed	Number of services	%
1	5	10
2	14	28
3	7	14
4 *	8	16
5	1	2
8*	1	2
11	3	6
Missing	11	22

*For 2 of the services, the 11 Navigators are shared between multiple sites

Of the 39 services which reported data, the demographics and professional background of A&E Navigators is reported in table 6.3

Table 7-3 Characteristics and professional background of A&E Navigators (n=39 services)

Category	Characteristic	Total (n)	%
Gender	Female	147	59.8
	Male	99	40.2
Ethnicity	White	98	33.4
	Asian	59	20.1
	Black	56	19.1
	Mixed	45	15.4
	Other	35	11.9
Professional background	Youth worker	106	32.0
	Personal experience of violence	63	19.0
	Education	55	16.6
	Other (profession)	46	13.9
	Social worker	20	6.0
	Nursing	19	5.7
	Healthcare, other than nursing	14	4.2
	Volunteer	8	2.4

This table demonstrates that 59.8% of A&E Navigators are female and 66.4% are of Black, Asian and other minority ethnic backgrounds. The professional background of A&E Navigators is mixed but most prevalent professional background is in youth work.

7.4.3. Focus groups and interviews

The qualitative data reveals a multifaceted role that blends youth work, advocacy, emotional intelligence, and systemic navigation. An effective A&E Navigator is defined not only by their professional knowledge and skills but also by a variety of attributes that enhance their ability to build trust, adapt to complex youth needs, and operate with empathy, flexibility, and resilience.

At the heart of effective A&E Navigator practice, as cited across all interviewee groups, is a youth-centred approach. Participants consistently emphasized the importance of consent-based engagement, allowing young people to lead their support journey in a manner that fosters trust and empowerment. As one participant noted,

"It was all kind of led by them... they would say this is what I want support with" (P7, A&E Navigator).

A&E Navigators avoid imposing support, instead offering tailored, flexible interventions that respect the young person's pace and preferences.

A&E Navigators' investment in trust-building means they often serve as the first point of disclosure for trauma, requiring a non-judgmental, empathetic presence. Effective A&E Navigators are described as "relatable," "authentic," and the non-clinical nature of their role enables them to offer a different engagement to other professionals in the hospital context. Navigators often use informal settings and peer-like communication to reduce power imbalances. The following quote captures this dynamic:

"*We're super professional, but you can kind of have those maybe more relatable conversations... we bring fidget toys... we can be a bit more relatable*" (P17, Social Prescriber).

The emotional demands of the role are significant. A&E Navigators encounter trauma, grief, and systemic barriers regularly. Emotional resilience, reflective practice, and peer support are essential, particularly given that many A&E Navigators report high levels of lone working. As one A&E Navigator shared,

"*This job can be heavy. It can be really heavy, so being able to sort of distinguish between that's my work and that's my home is absolutely key*" (P9, A&E Navigator).

Effective A&E Navigators need to be able to manage the emotional labour involved in the role, while maintaining professional boundaries and compassion.

A&E Navigators must be adaptable- "chameleon-like"- in their approach. They tailor support to individual needs, whether that means a walk in the park, a chat over fast food, or persistent follow-up over months. This means that flexibility in scheduling, communication, and engagement style is critical. One A&E Navigator described spending six months building rapport before a young person was ready to engage:

"*After the six months, it kind of all come tumbling down... he was ready then*" (P8, A&E Navigator).

As noted previously, lived experience is a powerful asset. Many A&E Navigators draw on personal histories of adversity to connect with young people authentically. This relatability can foster trust and break down barriers. However, this must be balanced with professional training and boundaries to avoid emotional overextension, or a narrow framing of the A&E

Navigator as only being defined by their lived experience. One A&E Navigator offered a personal insight on this:

'I've got lived experience, but I don't like to put that on my front. So, I think sometimes other people think oh this person can do it, because of whatever reason- because you're Black, because you've been shot because of whatever- but actually there's so much more that you need' (P28, A&E Navigator).

Effective A&E Navigators act as bridges between young people and often fragmented systems. They advocate within healthcare, social care, and criminal justice systems, often filling service gaps. Their role includes signposting, coordinating referrals, and challenging institutional barriers. Despite the informal nature of their work, effective A&E Navigators demonstrate high levels of professionalism, managing complex caseloads, operating autonomously, and engaging in ongoing learning. However, gaps in formal training and induction were noted, highlighting the need for clearer structured professional development for the role, and greater consistency across services.

Finally, passion for the role is a defining trait. A&E Navigators often go beyond their job descriptions, driven by a deep commitment to making a difference. One A&E Navigator reflected

"*More days are hard than they're not... you really need to believe in this"* (P11, Lead Staff).

This trait was not unique to the A&E Navigators, and the passion for the role held by HCPs, parents and lead staff is a key driver of their efforts in championing A&E Navigator services.

7.5. What challenges are experienced when implementing A&E Navigator programmes and how can these be overcome?

7.5.1. Literature review

A key challenge is the lack of designated physical space for Navigators within hospitals (32). Poor integration frequently correlates with this issue, as without consistent visibility or an operational base, Navigators struggle to become integrated members of the hospital team (36, 38). The combination of limited space reduced visibility, NHS staff turnover, and varying degrees of staff buy-in collectively undermines the consistency and impact of interventions in certain locations (40). Variability in working hours also affects whether Navigators are present during peak admission times (26, 34).

Inconsistent referral pathways represent a common challenge across programmes. Most referral pathways originate either directly from ED staff (e.g. (18, 36)) safeguarding teams (26) or hospital wards outside the ED (17). One programme in Wales takes referrals from a wide range of sources including paramedics, outpatient clinics, community nurses in minor injury units, brain injury units, mental health teams, schools, and other hospitals (28). These referral pathways are complemented by the A&E Navigators' proactive identification of eligible CYP, which is particularly valuable for identifying CYP who attended the ED when A&E Navigators are not available. In this situation they may receive phone, digital or paper referrals from staff or may review case notes (18). While the existence of multiple different routes for referral may increase the chances of CYP being picked up by a service they are also likely to cause confusion among already overstretched NHS staff as well as meaning that some CYP may be missed if there is no single point of contact for referrals.

An important barrier reported in multiple settings is the administrative burden placed on ED staff. Requiring overstretched A&E teams to complete lengthy referral forms is often unrealistic, leading to missed opportunities for intervention (35). In response, some providers have streamlined their referral forms to minimise time pressures. These experiences highlight how essential it is for referral pathways to be simple, clear, quick, and seamlessly embedded into hospital routines.

Fragmented data systems and the absence of shared outcome metrics complicate impact tracking (32). Some providers note difficulties in gaining access to ED admission records, which Navigators cannot access without honorary contracts with the NHS (34). This systemic limitation creates barriers to identifying eligible CYP and hampers the effectiveness of proactive intervention approaches.

Service providers face challenges with recruiting and retaining A&E Navigators. Contributing factors include lack of funding or short-term funding, emotional burnout, insufficient support, and job insecurity (32). High turnover among clinical teams also disrupts established working relationships and referral pathways (40).

External partnership networks present additional challenges. One evaluation noted that several listed partner organisations were either unaware of the Navigator programme or had never worked with them, highlighting the importance of fostering and embedding partnership networks with services in the community (37). Inconsistent buy-in from frontline clinicians further limits programme effectiveness in some areas.

7.5.2. Prospective Survey

Funding is a significant issue that has been reported in the literature and through feedback from sites. Figure 6.1 demonstrates that 78% of sites have funding for one year only. Figure 6.2 demonstrates that 56% (n=28/50) of services have been funded only since 2021 and 88% (n=44/50) since 2019.

This demonstrates how A&E Navigator services have a dual challenge to both establish themselves and build a sustainable, integrated service, whilst also being uncertain if they will have the funding available to exist beyond each financial year. This funding model is unlikely to create an environment to allow A&E Navigator services to become established, let alone flourish and develop.

Figure 7-1 Years of funding remaining for each A&E Navigator service

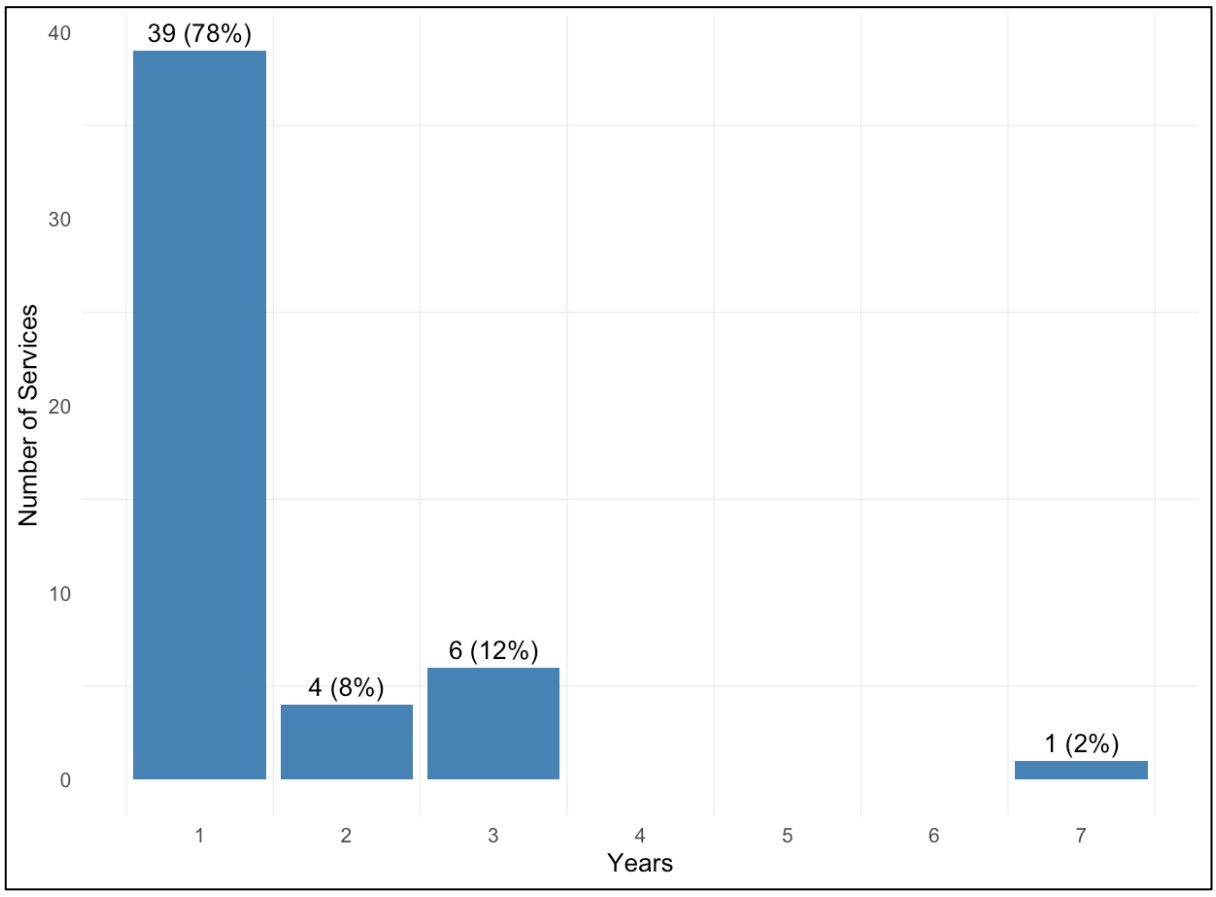
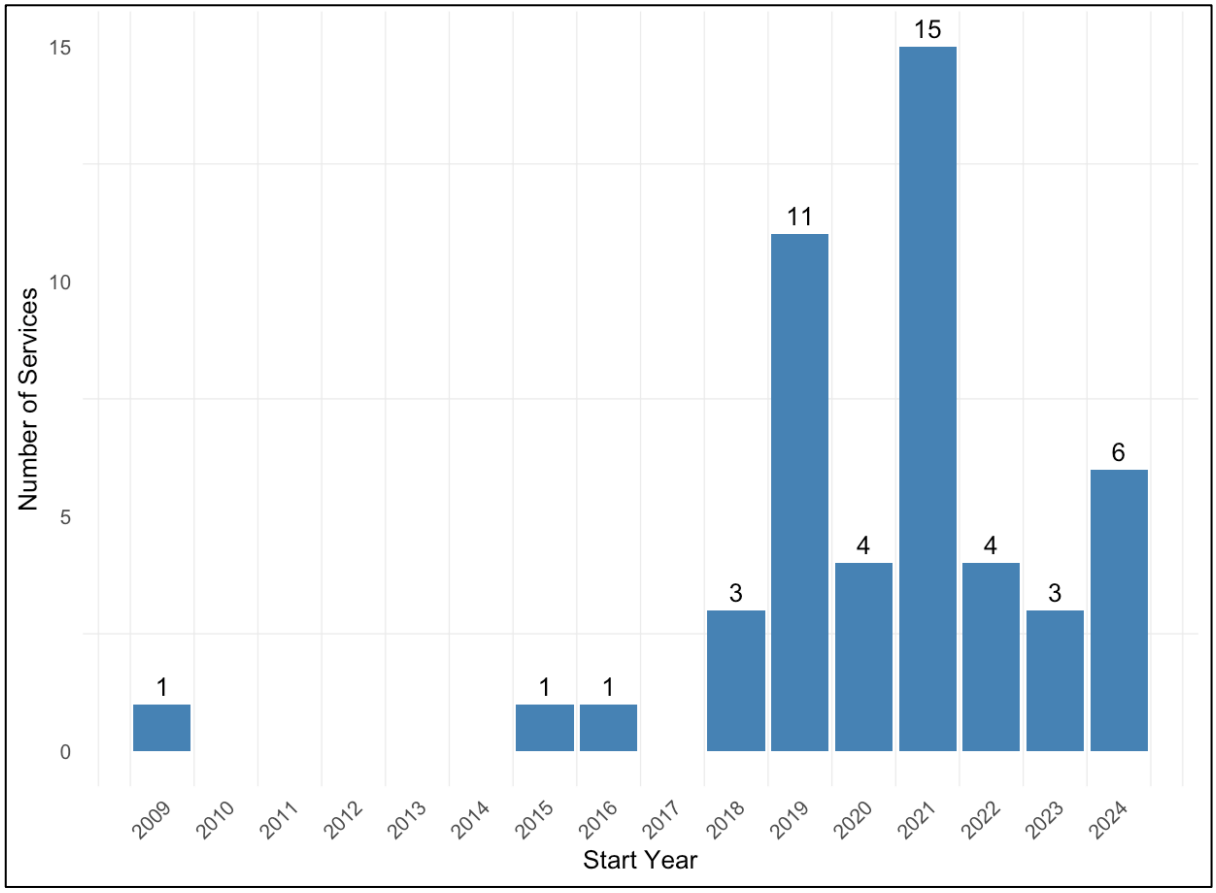


Figure 7-2 The number of services started in each year (n=49)



7.5.3. Focus groups and interviews

The implementation of A&E Navigator programmes faces a range of challenges, which are systemic, operational, and relational in nature. These challenges span from structural barriers within healthcare systems to the emotional demands placed on staff, and from interagency coordination issues to the precarity of funding. The later of these challenges -funding precarity- was the most consistently cited challenge amongst participants.

From the perspective of systemic and structural barriers, A&E Navigators often encounter fragmented referral pathways, limited or disjointed access to hospital systems, and bureaucratic hurdles that hinder integration. For instance, A&E Navigators, lead staff and HCPs all report challenges in relation progressing NHS honorary contracts, limiting the ability of A&E Navigators to fully integrate themselves within hospital systems. Different interview sites reported working through very similar challenges in isolation, so services end up re-inventing solutions to challenges that may have already been experienced and addressed elsewhere. As one HCP noted,

"There really should be some sort of national template for doing this, cause everyone's having to reinvent it on a site-by-site basis" (P27, HCP).

Collaborative working, with external agencies outside the hospital and a broad range of HCPs within the hospital, is integral to the A&E Navigator practice model across sites. This practice approach uniquely positions A&E Navigators and offers important opportunities for intervention, but it also presents challenges. Externally, the same funding precarity that impacts the A&E Navigators themselves can also mean that outside agencies and the professionals working within them are constantly changing, impacting the consistency of referral pathways. Within the hospital, EDs are noted for their high turnover of staff, meaning A&E Navigators have to spend a lot of time refamiliarizing incoming staff with their service. Poor visibility within EDs contributes to missed opportunities for early intervention. Some A&E Navigators reported feeling like outsiders within hospital systems, struggling to gain access to patient data or to be recognised by clinical staff.

'It took quite a while for us to become part of the furniture... you go back the next day and they've not remembered you from the day before' (P8, A&E Navigator).

Barriers to engagement with young people also pose significant challenges for A&E Navigators. Mistrust and the stigma associated with police or social services can hinder initial contact and sustained engagement. A&E Navigators emphasised the importance of empathy, persistence, and relationship-building, however, this can leave A&E Navigators struggling to juggle competing demands and time constraints. Clarity and a shared understanding in relation to service delivery model and theory of change can offer greater clarity for Navigators in prioritising caseloads and making decisions in relation how best to make use of timebound contact with young people. As one A&E Navigator noted:

'*Our referral criteria is so broad... not every referral is from a young person that's been a victim of violence*' (P1, A&E Navigator).

Emotional labour and role complexity can present challenges for A&E Navigators. As discussed previously, the passion many A&E Navigators have to make a difference can lead them to operate beyond their formal roles, providing emotional support, advocacy, and even informal counselling. This blurring of boundaries can lead to burnout, especially when staff are exposed to repeated trauma. This raises important considerations in relation to recruitment, induction and the on-going training and support for A&E Navigators.

'I spent the whole day with her yesterday… that's probably not the best, but I don't want to say no' (P2, A&E Navigator).

Despite the challenges noted above, A&E Navigator services have adapted at a local level in a manner that has enabled them to mitigate the impact of these challenges, mitigations include:

- Boundaried practice: Offering greater clarity on the boundaries of the A&E Navigator role (as well as its potential) can be enabling for A&E Navigators and the CYP they work with. This requires strong strategic leadership and direction in relation to the practice approach and theory of change being adopted.

- Training and support: Ongoing professional development, trauma-informed training, and peer support structures can help staff manage emotional demands and maintain role boundaries.
- Embedding A&E Navigators in hospital systems: Increasing visibility, securing dedicated space, and fostering relationships with clinical staff (including the ability to share important patient information) can help integrate A&E Navigators more fully into hospital workflows.
- Sustainable funding models: Long-term, stable funding is essential to retain experienced staff and build institutional memory.
- Strategic interagency collaboration: Clear protocols, shared systems, and mutual recognition across agencies can enhance coordination and reduce duplication or gaps in care.
- Networking and practice sharing: Networking and practice sharing approaches have emerged at local, regional and national level. Greater consistency and strategic direction would enhance the impact of these networking and practice sharing efforts.

7.6. Are there specific models/examples of best practice that could be adopted more widely?

7.6.1. Literature review

While the literature review did not specifically point to an overall exemplar of best practice, the existing evaluations did outline characteristic of individual services that helped them to work well in terms of both supporting CYP and working in collaboration with their NHS partners.

A&E Navigators represent a diverse workforce in terms of professional experience; most are support workers who may be youth workers (18) NHS workers e.g. nurses (27, 28) or volunteer workers (30) who support CYP attending EDs with injuries related to violence. Some, but not all, services emphasise the importance of A&E Navigators having their own relatable lived experience. A&E Navigators may share past experiences or backgrounds with some of the CYP e.g. of violence, victimisation, racial discrimination or other issues such as homelessness. Recognising that the A&E Navigator has walked in their shoes can help CYP to realise that their situation is not hopeless and that there is an alternative path they can choose. Lived experience can also make A&E Navigators easier to trust and can aid engagement (30).

Integration into NHS teams who can see the A&E Navigators' value is key from the perspective of A&E Navigator services (30). From the NHS viewpoint, willingness of the Navigator service to be flexible (37) both in terms of availability and recognising demands on NHS staff time, i.e. making the referral process easy (36) are key elements that foster strong collaborations. Both A&E Navigators and NHS staff working in the majority of services evaluated did consider their A&E Navigator programmes were well integrated into their respective NHS departments.

Evidence would suggest that those services that are better integrated with NHS staff and safeguarding teams and more visible to ED staff are more effective in terms of the percentage of CYP who initially engage with the Navigators. Better integration also seemed to support longer term engagement by CYP, completion of programmes and reductions in future ED attendance (30, 34).

Other important factors contributing to success were professional training and support for A&E Navigator teams and the value attributed to the service by the NHS staff. (36, 37). Outside the NHS strong community partnerships enabled effective connections between the hospital and community services for the CYP (31).

The trusted relationship built with the CYP seemed central to the success of A&E Navigator programmes and this was noted by the majority of evaluations (e.g.(29, 36)). Engagement also seems higher where the A&E Navigators meet the CYP face to face at the time of their visit to the ED (17, 29, 30, 34), which is often out of hours or at weekends. This is particularly the case if the CYP is seriously injured which increases the length of admission (30). Where the first contact is made by telephone after the acute presentation, engagement is reported to be less successful, and this has been attributed to reduced motivation to participate by the young person but could also be attributed to mistrust of services more generally (30). Initial face to face engagement does seem to foster trust between the CYP and the A&E Navigators and that, alongside a relational approach (27, 36-38), are consistent themes across the literature which appear to exemplify best practice in terms of the interactions between A&E Navigators and CYP.

The support of parents, or carers, can also be a factor in the success of an intervention, with CYP more likely to engage if their parents, or carers, are supportive (35). Finally, a process of co-design with CYP is another factor contributing to success which presumably helps CYP feel more invested in the service. (32)

7.6.2. Navigators as part of ED, hospital and community systems

Across clinical contexts in England and Wales there is greater awareness, and in interview sites, increased buy-in around the A&E Navigator role. This recognition and visibility is crucial within hospital settings for A&E Navigator teams to be part of coherent services that work across teams and within already complex and sizeable hospital systems. A&E Navigator services across England and Wales are relatively novel, operating through varied practice models, where this variation is important in responding to community-based vulnerabilities. However, within the interview sites of Manchester, Leeds and Cardiff, A&E Navigator services are seen by clinicians and A&E Navigator staff to operate most effectively in delivering violence reduction and prevention when they are designed and operated as part of integrated services, working to tackle health inequalities at a population level. For A&E Navigator services to operate effectively, committed delivery teams are required, supported by consistent

funding and allocation of staff time, to drive through changes at different levels towards effectively tackling the myriad causes and outcomes of violence.

7.6.3. Definitions of violence and funding criteria

Strict funding criteria focused on serious violence related injuries can limit the early identification of CYP who are facing other forms of violence and harm and can ignore the associations of other forms of harm with violence. It is vital that efforts in prevention are driven further upstream where possible as this can prevent CYP becoming victims or perpetrators of serious violence. There is a growing awareness of the interconnected nature of violence, abuse, and adversity, which emphasises the limitations of artificial silos of different forms of violence. In practice, where services have the funding and latitude to respond to all CYP in the ED they reported often being the point of 'first disclosures' of often hidden forms of violence, including domestic violence and abuse, sexual violence, violent bullying, and self-harm.

It is important that A&E Navigator services do not create a hierarchy of violence and only respond to that which is most visible or more obviously related to criminality. By offering enhanced opportunities for early disclosures, ED services could potentially become sites of authentic early intervention, instead of just post-serious violence services, when young people are at a much later point in their involvement in peer violence. Linked to this point, through enabling a more widely accessible A&E Navigator service it also enhances the opportunity to recognise and intervene with CYP with other support needs that are concerned with self-violence (self-harm, substance abuse, mental health, eating disorders). In Hampshire much of their caseload were CYP admitted to hospital after overdoses. While A&E Navigator services were commissioned to support CYP with issues relating to violence it is vitally important to recognise the clear links between violence and other forms of harm such as substance use (41, 42). A&E Navigators by acting as a first point of contact can then make links with existing NHS and other services that can support young people with these or advocate for their existence by sharing information. This is a vital point of intervention for vulnerable young people which should be given the same weight as intervening in other forms of violence and harm and may prevent escalation to serious violence. However, our fieldwork suggested that VRUs often fund related to crime prevention only, likely related to their organisational aims and objectives, and thus deprioritise the other harms that CYP face, which they assume will be funded by health.

7.7. Descriptive profiles of the five A+E Navigator services

While our research was not designed to comment on A&E Navigator programme outcomes meaning we cannot hold up exemplars of best practice in terms of reducing violence or associated injury, we were able to look in depth at our 5 interview sites and produce a profile of each of these. These descriptive profiles are useful for comparing models of practice across the country and to allow exploration of similarities and differences. They also allowed us to outline key successes and challenges as described by the staff working in the programmes. These profiles represent a snapshot insight on service delivery within the 5 interview sites, however, as noted previously, the landscape of service delivery within and across sites is continually shifting.

7.7.1. Hampshire

- **Sites:** Four in Hampshire; one Paediatric MTC since 2020, three TU's since 2021-22.
- **Location:** MTC based team in the ED, other services are off-site.
- **Availability:** MTC team, Monday to Saturday 8AM-8PM, with shorter hours on Sunday; other services available on weekdays, 9AM-5PM.
- **Staff:** Nine. Two services employ three-four A&E Navigators, the remaining two, one A&E Navigators each.
- **Engagement:** Aim is for a short, goal-based intervention, typically lasting four sessions, with YP referred on to relevant support services within three months. Support ages 5-25.

Hampshire runs a youth-focused social prescribing model; a holistic, young person-centred approach that addresses the social determinants of health by connecting young people to a wide range of community-based services. The aim is to reduce hospital readmissions by addressing the root causes of issues and promote mental and emotional wellbeing. They offer immediate assistance and crisis intervention in EDs to CYP who present at hospital with violence related injuries, as well as young people presenting for other reasons- including suicide attempts, self-harm, substance use and abuse issues, mental health challenges, eating disorders, accidental injuries. Beyond ED they connect CYP with specialist support and community services, aiming for a smooth transition from hospital care back into the community. Additionally, CYP can be supported around practical issues such as housing, homelessness, money educational and employment challenges. Youth workers here suggest they have built relationships with hospital staff that ensures the service is well-integrated and more responsive to the needs of young patients. Collaboration with hospital staff is crucial, and youth workers raise awareness and train staff on the specific needs and challenges faced by CYP. A key challenge to this work was being able to reach children who have been directly impacted by serious violence (including knife related injuries) as these children tend to bypass the wards the youth workers are predominantly located in. The difficulty in logistically

reaching victims of this nature, as well as the overall low numbers in the region, have impacted the service funding streams. Over time funding from crime-prevention related funds (including Police and Crime Commissioners) has reduced, and instead they have necessarily pivoted to a more public health related focus with closer relationships with CAMHS.

7.7.2. Manchester

- **Sites:** Five in Greater Manchester; three MTC's, two TU's; Run by Oasis from 2021.
- **Location:** All A&E Navigator services physically based outside of hospitals.
- **Availability:** weekdays, typically afternoon and evening but responsive to need.
- **Staff:** Service employs 15 people across sites, 11 are frontline A&E Navigators.
- **Engagement:** Initial model offered six-eight weeks of support with some cases needing longer support; in the current model, a typical timeframe for support is six months. Support ages 10-25.

Clinical input was key to conceptualisation and implementation across the sites with current services evolving from hospital-based models to broader, community-integrated approaches, responsive to young people's needs around a range of social, emotional, and mental health issues. Navigator services have developed new initiatives responding to evolving understandings of contributing factors to involvement in violence; for example, referrals by primary care medics for children not attending hospital, QR codes on ambulances, custody suite and parent support, and support for young people showing risk factors, thus moving beyond an ED model. This multi-practice approach is a unique aspect of the services operation across Greater Manchester. Navigator support is face-to-face if requested by CYP or can be by telephone. Onward referrals for support are made once navigators have finished support or where an immediate need, e.g. mental health presents. Challenges faced include difficulties integrating the A&E Navigator role within hospital and custody systems, e.g. accessing patient data, limited visibility in the ED and externally, poor inter-agency communication and lack of feedback from referred services.

7.7.3. Leeds

- **Sites:** Two city-centre based sites; one MTC, one TU; Running from 2021.
- **Location:** Both within the hospital, a few minutes walk from the ED.
- **Availability:** 9AM-5PM weekdays, scheduled out-of-hours times and to respond to immediate need.
- **Staff:** Service employs five people, four of which are frontline A&E Navigators.
- **Engagement:** Six-week engagement guideline but can support for longer where necessary. Support ages 11-25.

Services have been shaped by existing provision; specifically, youth work infrastructure already present in hospitals, trauma service and a vision of addressing health inequalities and vulnerabilities. The aim is to provide immediate, on-site support in EDs on weekdays, engaging CYP with injuries from violence or presenting other serious risk at this critical moment; additional out of hours support is also offered via face-to face delivery of activities within the hospital setting that young people coming through the service can attend. Alternatively, CYP are referred and contacted by phone. Beyond this, the service refers CYP to community services and specialist support for follow-up care to support the transition from hospital to community. Similar to Manchester the A&E Navigator role/ service, as a broader health inequalities approach, has faced challenges working within hospital systems, but recognition has improved and can improve further. Effective collaboration with healthcare, police, and social services in crucial and can be pressured when services are stretched to capacity. Lack of consistency in both funding and allocation of staff time have proved an issue to delivering a coherent service that works effectively across teams.

7.7.4. Cardiff

- **Sites:** One; an MTC.
- **Location:** Hospital-based staff work alongside A&E Navigators who are based off-site.
- **Availability:** Weekdays from 6AM-5PM, sometimes later into the evening.
- **Staff:** Four. The hospital-based team has two full-time staff: one nurse (A&E experienced) and one advocate (background in policing and sexual violence). Action for Children team includes two A&E Navigators with youth work backgrounds.
- **Engagement:** No specific timeframe and support is based on need, support ages 11-25.

The model here is an NHS and community organisation collaboration that integrates expertise across the two distinct spheres, allowing for flexible, responsive and holistic care. For example, the nurse role integrates the service into existing ED systems and practice with NHS embedded staff making referrals to the community-based Navigator team. This collaborative approach has helped in ensuring a more seamless integration into hospital systems from the inception of the service. Criteria around violence are intentionally broad and NHS staff support all cases involved in violence and exploitation that are not domestic abuse related (where a dedicated team exists). The model has had success in developing community and medical responses, including advocacy, safeguarding, and practical help. A unique aspect of the service is the clinical based data-driven approach; early identification of trends in injuries or offending and developing preventative responses. As with other locations challenges include precarity of funding, navigators lack of physical presence in the hospital and bureaucratic constraints, for example as an NHS role governed by statutory processes there can be limitations on information sharing.

7.7.5. London

- **Sites:** A&E Navigator services run through several organisations and funding models across the city, including Redthread, St. Giles Trust, Oasis.
- This profile focuses on The Royal London Hospital who run a local council/VRU funded A&E Navigator violence reduction service. Running from 2019. A separate team offers support to inpatients delivered by St. Giles Trust.
- **Location:** Physically located within the hospital more than two minutes' walk from A&E.
- **Availability:** A&E Navigators available on weekdays, during daytime hours but also some evenings and responsive to need.
- **Staff:** A&E service employs three A&E Navigator staff: specifically, lead and two case workers.
- **Engagement:** Dependant on each case; three, six and twelve months are used as milestones to evaluate cases. Support up to ages 25 but some flexibility for individual cases.

Following the inception of a ward-based service in 2015, the A&E Navigators began in 2019, both developing from the recognition that young people were treated for injuries by the NHS but that a model that treated violence at the source was necessary. Support and violence prevention here is perceived as holistic when it is integrated with clinical systems but responsive to young people's and family's needs beyond the hospital. Navigators here have extensive professional and lived experience of the community and landscape, bringing cultural competencies to the role. They work dynamically alongside medical department teams and the St Giles workers to respond to complex and shifting needs in addressing multifaceted causes and impacts of violence, establishing trust with young people and maintaining consistency in support offered by the service and specifically tailored referrals to further services. As a council run initiative, the service is unique to third sector provision in the way it can offer immediate safeguarding responses to incidents of violence. A&E Navigators sit within community safety teams so remain non-statutory and can offer confidentiality in responding to victims in the ED: but communicate details of events to coordinate on the ground responses via community enforcement officers, CCTV teams and detached youth work teams towards offering responses to violence beyond the victim. However, this borough-focused approach brings limitations, where ongoing support is only available for Tower Hamlets residents. At a broader level further challenges include year-by-year funding and resulting pressure on the service including demand exceeding staff roles and capacity. In terms of early intervention, A&E Navigators highlighted the importance of secondary prevention. Specifically, greater recognition of the lack of correlation between injury severity and future risk and better support for discharged patients.

8. Limitations

Here we outline some of the key limitations of our review and research into A&E Navigator services in England and Wales.

8.1. Literature review

The literature review was limited to studies published after 2021 to ensure there was no duplication of previous reports or data synthesis exercises. Whilst existing data is already in the public domain, by limiting dates, important messages from earlier literature may not be present in this report. Whilst the literature search was robust and transparent it was not a systematic or rapid review, and no quality or risk of bias assessments were performed. It is therefore not possible to accurately provide weight to the information provided in the literature review sections.

8.2. Mapping of available A&E Navigators

Whilst every effort was made to identify all A&E Navigator sites via established emergency medicine networks, VRUs and established navigator services, 37 sites did not respond to our mapping survey. This may have resulted in under-reporting of the number of A&E Navigator services.

8.3. Mapping against need

While the methods used to generate travel time distances from each population-weighted centroid usually produce coherent modelling, occasionally in urban areas of dense road networks and multiple hospital sites, some LSOAs may be assigned to a hospital that appears visually incongruent because it may seem further away.

Greater Manchester Police does not report crime statistics in the same manner as the other police forces in England and Wales. Sites whose modelled catchment areas overlap with this police force area are excluded from analysis about crime statistics meaning we were unable to produce a complete picture for this area.

8.4. Survey of A&E Navigator services

The key limitation of the survey was the response rate. We made use of the TERN network as well as emails to known Navigator ED sites and VRU Directors to reach out to A&E Navigators sites we may not have been aware of. Whilst 67.6% (50/74) is an acceptable response rate and provides relatively robust data. However, if the third of A&E Navigator services who did not respond, had answered the survey, our reported results would likely be different. The survey was 78 items long. Responder fatigue is a known phenomenon and can result in a decrease in quality of responses towards the end of surveys. It cannot be ruled out for our survey due to its length (43).

8.5. Focus groups and interviews

Qualitative interviews were performed in 5 sites, or 6.8% of known A&E Navigator sites. In addition to the interviews, we also conducted 2 focus groups. Whilst qualitative interviews provide a depth and context absent in the quantitative surveys, there are likely to be views under-represented in the qualitative work due to the small sample size. We were also unable to interview any CYP, and this meant reliance on the views of A&E Navigator staff, parental perspectives and the existing literature in relation to factors relating to issues such as engagement and attrition. The views of CYP are central to the success of these services and this should be pursued in a future study.

9. Discussion

9.1. Funding and outcomes

Funding is a key issue that was identified in the literature, surveys, interviews and focus groups. A lack of secure funding and one year funding extensions, makes any long-term planning, recruitment and retention of staff, training and development of staff, development of service infrastructure or measurement of outcomes challenging.

Despite these challenges it is important to note that across England and Wales these services are being funded on a scale far bigger than anticipated. The presence of A&E Navigators in a third of EDs in England and Wales, highlights the acceptance of A&E Navigator services as a key service VRUs are keen to commission, and ED's are willing/keen to facilitate. However, there remain significant areas of England and Wales with no services (mid and North Wales, East Midlands, East of England and Southwest England).

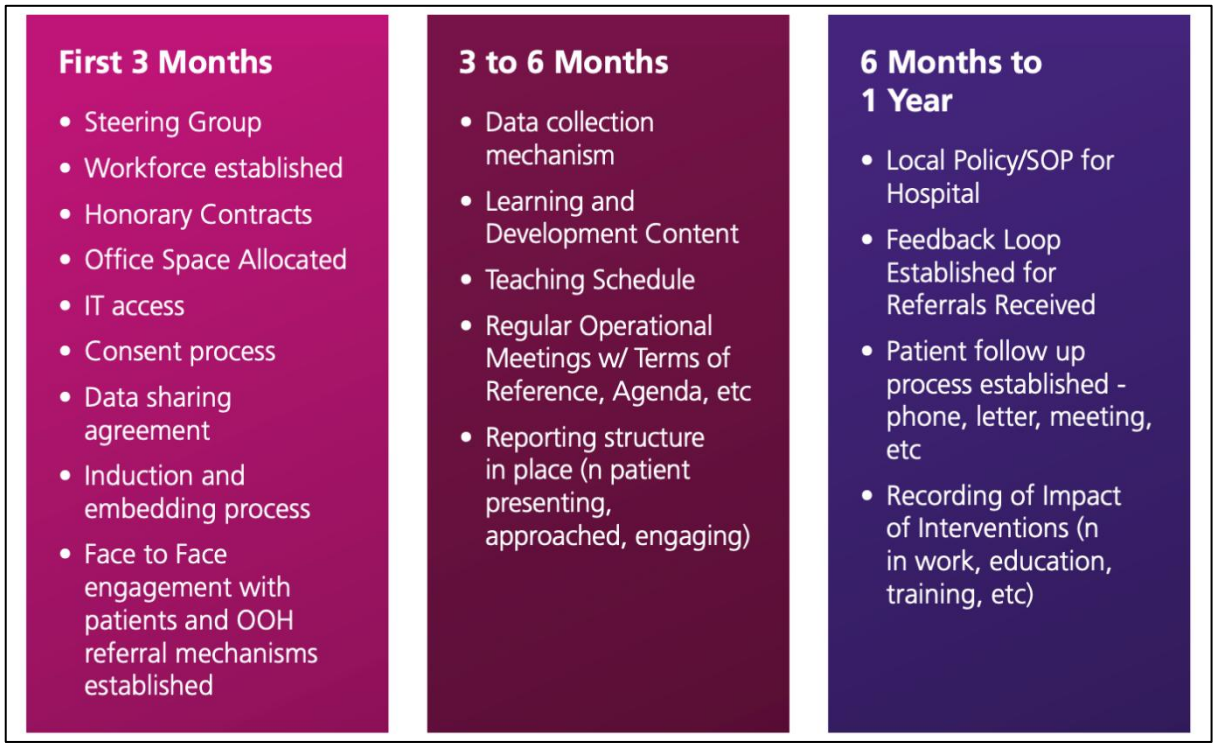
Despite a lack of definition of 'local need' or an objective assessment of need at a regional or local level, the tables and figures presented in this report provide a general overview of where A&E Navigator services are concentrated in England and Wales. This data can support national and regional policy makers to consider the potential requirement for A&E Navigators in their regions and use their local knowledge to supplement the deprivation, crime and ethnicity data presented.

Despite the widespread proliferation of services, funding does not appear to be linked to outcomes or the 'success' of the service. As an example, A&E Navigator Services in Liverpool and Nottingham have been cut in March 2025 and 2024 respectively, despite high quality evaluations demonstrating their value. (17, 36) A clearer pathway between outcomes and funding is urgently required. Many of the evaluations undertaken thus far have concentrated on process and while these have given insight into how the services work and who they work for, the important progression from this should be 'are they effective in supporting young people and in reducing their involvement in violence'. This would allow funding to be directed appropriately to reinforce the services that are effective in producing these outcomes and would allow other services to learn from best practice. The Redthread services, for example, can evidence reduced reattendance at the ED as a result of violence (18) for the CYP who engage with their programmes compared with those who did not engage.

In 2022, The Violence Reduction Programme London, published an excellent implementation guide for in-hospital violence reduction services (including EDs or A&Es). (44) This includes a clear guide for services from implementation through to outcome data collection. Importantly, it provides a list of key performance indicators (KPIs) for a newly established service. These KPIs could be utilised by new A&E Navigator programmes, and commissioners, to link future funding commitments, rather than the current status quo of short-term annual funding cycles. It also allows commissioners, A&E Navigator services and clinical teams to have

realistic expectations of timelines to an embedded service. Figure 8.2 below is taken from this report and demonstrates the steps that need to be taken in the first year to get a service up and running. Our work would suggest this is an ambitious timeline and will require the full support of all key stakeholders to be achieved.

Figure 9-1 Expectations for setting up and delivering an in-hospital VR service for the first 3 months to 1 year



This report highlights that VRUs are a significant funder in over 70% of services. It is therefore likely that funding commitments, or commissioning, is reliant upon the annually allocated VRU budgets. Whilst this work did not seek to understand how and why VRUs allocate funding to specific areas under their remit, it is important to note that VRUs are themselves funded on an annual basis by the Home Office, which builds some insecurity and uncertainty into the system and makes long-term investment in A&E Navigator programmes challenging. According to the government website outlining VRU funding allocations for 2023/24:

"Any award of…VRU funding is subject to receipt of proposals relating to the use of funding and to these plans being agreed by the Home Office, as well as receipt of all other necessary approvals, including approval of HM Treasury."(45)

Whilst this is the landscape to date, and we note the A+E navigator services that have not been funded in the 2025/26 financial year, it is important to highlight the new Labour government's commitment to navigators in its election manifesto. They plan to:

"…place youth workers and mentors in A&E units" (1)

It is therefore likely that funding, via VRUs, will become more targeted and ring-fenced towards A&E Navigator programmes. Services therefore could consider aligning themselves to the implementation and KPI standards outlined in the 2022 Violence Reduction Programme London report to ensure a standardised approach to roll out, delivery and outcome measurements in England and Wales.

9.2. Service delivery differences and national co-ordination

While we do feel that attention should be paid to aligning with the implementation guide referenced in section 8.2, it is natural for each service to develop its own approach and delivery model, responsive to the local needs of CYP and the available resources in healthcare, social care and the third sector. However, with many A&E Navigator services now available throughout England and Wales (and indeed Scotland), it is vital that collaboration, co-ordination and information sharing is facilitated, to allow best practice to be shared.

In the USA, Navigator type services come together in the Health Alliance for Violence Intervention(46). This organisation aims to advance hospital-based violence intervention programmes, alongside community programmes and provides a co-ordinated public health response. The organisation also produces national standards for hospital-based violence intervention programmes.

In the UK, there have been previous successful attempts at co-ordination including the Hospitals Interrupting Violence Exchange (HIVE), organised by Redthread. This forum was relaunched in 2023 after a three-year hiatus following COVID but now seems to have ceased following their merger with Catch-22. (47) In Leeds in 2023, there was a national A&E Navigator conference (48) and in 2025 there have been several regional events. However, none of these currently allow a national hub for co-ordination and practice sharing for either A&E Navigators or those working in other settings such as schools or custody suites. This results in services working in isolation and unable to seek support from longer established services when needed. At present approaches for advice happen on an ad hoc basis and it would be useful to have a central source of information and advice. In focus group conversations A&E Navigator staff commented on the frustration of having to reinvent the model on a case-by-case basis.

As highlighted in section 8.2 above, the 2022 Violence Reduction Programme London guide could provide a framework for allowing services to embed and grow in a standardised manner, whilst adapting their processes to the local context and need. This is important for areas including staff training (including in key areas of race equity, professional boundaries, trauma informed practice and others); hospital embedding processes (including IT access, physical office space, clinical staff awareness of the service) and outcome measurement, including the use of routine health and police data which will require the development of information sharing agreements.

9.3. Definitions of violence

It is known that CYP who suffer violence are more likely to return to ED with an injury related to violence than CYP who have been injured in a non-violent manner (relative risk [RR], 1.65 [95% CI, 1.25-2.14]; *P* < .001). This work from America also highlights increased risk of ED re-attendance or death in CYP who are of female sex (RR, 1.30 [95% CI, 1.02-1.65]), have a diagnosis of a drug use disorder (RR, 1.29 [95% CI, 1.01-1.65]) or a diagnosis posttraumatic stress disorder (RR, 1.47 [95% CI, 1.09-1.97] at their first ED visit with violence related injury. (49)

However, this data does not designate the severity of the underlying violence related injury. It is likely that the severity of violence related injury ***does not*** predict the future likelihood of poor outcome such as death, significant disability, ED re-attendance or involvement in the criminal justice system. The psycho-social drivers that lead to the violent incident resulting in ED presentation are likely to be similar in a case of life-threatening injury due to violence when compared to less severe injuries due to violence .Whilst there is a lack of high-quality evidence exploring how injury severity affects the impact of an A&E Navigator intervention, our qualitative work suggests both groups receive significant benefits from A&E Navigator interventions.

Within UK healthcare systems, the most severely injured CYP will be transferred to an ED at the regional MTC, rather than staying at their local ED in a TU. Due to the concentration of the most severely injured CYP at MTCs, there may be an argument for the concentration of A&E Navigator services at these sites. Our survey work did identify the highest number of mean A&E Navigator referrals at MTCs, however, a significant number of referrals for CYP with violence related injuries were still made to services based in A&Es at TUs. Decisions on the regional roll out of future A&E Navigator services, should consider high risk local areas (as identified by our mapping in Section 6), the likely number of potential referrals and design a referral system that enables CYP to be referred and seen by an A&E Navigator irrespective of the hospital they happen to present to or their severity of injury.

We did not collect the specific numbers of individuals presenting with specific types of violence referred to A&E Navigator services. However, we know from survey data that services accept referrals for CYP who have suffered physical violence (96%), social vulnerabilities (71%), CYP presenting with sexual violence (65%) and domestic abuse (55%). Designing services and providing interventions for CYP with such wide-ranging presentations related to violence requires significant planning and skill. It is also important to note that 40% of all referrals were for woman and girls. Designing services that are adaptable to the CYP, and their circumstances is likely key to ensuring a well informed and inclusive service for all CYP and all types of violence and associated social vulnerabilities.

It is important to consider that CYP who attend the ED with injuries and health concerns may be experiencing violence (as victims, perpetrators, or both) or trauma in the wider context of their lives. It is remiss to attach funding only to the presenting injury classification, when

successful services have been reporting engagement from young people experiencing hidden harm from others, or are harming themselves (through self-harm, eating disorders, or suicide attempts). Such self-directed violence can often be related to other experiences of harm in children's lives and so should be considered as a potential point for early intervention, which may (or may not) serve as prevention of later violence. For example it is well known that the experience of 4 or more Adverse Childhood Experiences puts CYP at significantly increased risk of involvement in violence, both interpersonal and self-directed, later in life whether as a victim or perpetrator. (50) The Serious Violence Prevention Duty has placed a statutory onus on local authorities to evidence their proactive work in preventing 'serious violence', which has arguably instigated the initial commissioning of widespread A&E Navigator services. However, local areas have the discretion to define violence that is considered serious in their local areas which is related to the gravity score. An offence's seriousness, or 'gravity score' is scored out of eight, ranging from one (least serious) up to eight (most serious). The offence list reflects that of the Police National Legal Database (PNLD) and is in line with other criminal justice agencies. (51)This test can easily miss more hidden and pernicious forms of violence in CYP's lives. Our findings suggest that there is substantial value in a more expansive referral criteria for young people to access support in the ED, which may reach CYP at an earlier point and be a valuable preventative measure. This argument may be useful in considering other sources of partnership funding e.g. from Health that may justify expansion of the A&E Navigator remit as the Navigator approach of person-centred relational practice could also apply to supporting CYP with these wider issues.

The fieldwork interviews emphasised that A&E Navigators are often a vital point of 'first disclosure' for CYP who are experiencing various forms of gender-based violence, and notably, these disclosures were not always related to the injury/health issue that the child was presenting at the ED with. This highlights the important potential of A&E Navigators in recognising hidden forms of harm that CYP are experiencing. The importance of the provision of child focused and impartial contacts with youth workers, such as can be offered in the ED, should not be underestimated.

Regarding gender-based violence, which can include sexual violence, domestic abuse and sexual exploitation, it is crucial that A&E Navigators have appropriate training and awareness of the use of the Domestic Abuse, Stalking, and Harassment Risk Identification Checklist (DASH RIC), referral pathways into Sexual Assault Referral Centres (SARCS) and Multi-Agency Risk Assessment Conference (MARACs) and other support organisations. A&E Navigators should also remain mindful that many risk assessment tools and systems (DASH and MARACs) are designed to assess immediate risk of harm and homicide of the intimate partner within a Domestic Abuse context and so do not always adequately reveal the harms to CYP residing in homes where there is Domestic Abuse. A&E Navigators need to work in partnership both with statutory safeguarding bodies and local specialist services to provide specialist onward support. These cases have significant potential to generate vicarious trauma for staff supporting victim/survivors and so appropriate support for them should also be available. It

may be appropriate for A&E Navigators to undertake IDVA or ISVA training. A briefing from SafeLives outlines the benefits of having IDVA trained staff in health settings. (52)

It is worth reiterating here that A&E Navigator services have almost organically not limited themselves to supporting CYP solely with issues relating to violence, many services provide much more holistic and whole family support with a much wider range of issues. This perhaps suggests that the A&E Navigators on the ground, many of whom are youth workers by training, have a clear understanding and experience of the drivers of violence. Their unique position in the ED and the trusted relationship they foster with the CYP offers them the potential to identify other issues affecting CYP early and to offer intervention and support. It is important therefore that although these services aim to reduce violence as their primary outcome that attention is paid to their potential to contribute to prevention in a wider sense by addressing some of the social determinants of violence.

9.4. The importance of resilience, time and integration

We noted that 38.8% of services (n=19) employed only 1-2 A&E Navigators while others with larger numbers of staff spread those over multiple hospital sites resulting in small numbers of staff at each site. Smaller teams inevitably mean that A&E Navigators are not available on a seven day a week basis in most areas and many services are only operational during normal working hours (Monday-Friday 9-5) and this may not be when CYP present to the ED. Small teams are less able to be resilient in terms of responding to service need and issues such as staff sickness and annual leave and rotas will be less flexible. In addition, it will inevitably be the case that some patients will be unsuitable for lone working in community settings. Most services did not make use of sessional or part time staff to fill rota gaps.

In addition, where there are only 1-2 A&E Navigators the service caseload will inevitably be smaller, and it will take more time to build a body of evidence that demonstrates the longer-term outcomes of the service. This introduces another challenge to services that have short term or precarious funding and to organisations who are brought into evaluate them as they are unlikely to be able to demonstrate the true long-term benefits of their service with only short-term data. There will be considerable pressure on services to demonstrate their value, but it is important that funders exercise some pragmatism around what is feasible in the time available.

As stated above, hospitals and ED teams that value and integrate the A&E Navigator role into their clinical ecosystem appear more likely to benefit from the programme. For NHS funded and nurse led services this is likely to be easier than for external organisations. Often local ED clinical ‘champions’ or leads makes integration much more straightforward, as that person can be the link between the service and clinical staff. Integration can also be viewed as a two-way street and A&E Navigators often have a skillset that can prove vital in busy EDs. This can include supporting and calming CYP while they are having a procedure or test done or supporting with de-escalation when this is required.

9.5. Race Equity

Race equity was defined by the organisation Race Forward as follows:

***"Racial Equity** is a **process** of eliminating racial disparities so everyone can have the same outcomes. It is the intentional and continual practice of changing policies, procedures, systems, and structures by prioritizing measurable change in the lives of people of color and other marginalized populations*." (53)

As outlined in a previous YEF report, race equity should be seen as both an outcome and a process whereby a person's race does not predict their outcome AND work is undertaken to address the root causes of race inequalities within a project or service. (54) The report outlines ways to address race inequalities including undertaking an equality impact assessment, having relevant policies and procedures in place, being mindful of any biases showing up in evaluations, partnering with community organisations that reinforce race equity and being mindful of intersectionality which may amplify race equity issues. In our report 77.6% of services had policies outlining their organisational approach to race equity.

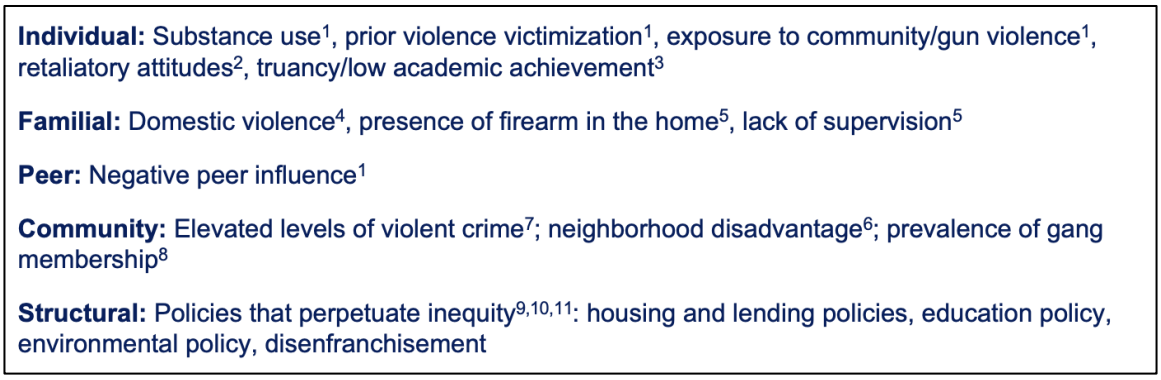
It is important to note that when we talk about youth violence, CYP from certain racial and ethnic backgrounds in England and Wales are disproportionately more likely to be victims and perpetrators of violence and disproportionately represented in the criminal youth justice system. (3) This is despite most victims and perpetrators of violence in England and Wales being from White backgrounds.

It is important to recognise the role of institutional surveillance and criminalisation in shaping trust and participation when considering engagement with A&E Navigator services among Black and other minoritised young people. CYP from racialised communities often encounter multiple forms of scrutiny, through policing, schools, healthcare, and social services, which can lead to a perception that support services are intertwined with systems of control or punishment. Arun Kundnani (2007) and Remi Joseph-Salisbury (2020) have argued that these dynamics erode trust and confidence and create alienation which can deter young people from engaging with interventions like A&E navigators. For A&E Navigators, offers of support may be met with hesitation, mistrust or refusal, especially if the service is perceived as connected to statutory agencies e.g. in the criminal justice sector. (55, 56)

Research from the USA which analysed the facilitators and barriers to Black and Latinx youth engagement in hospital violence programmes identified four key interpersonal factors that help facilitate engagement. These were 'Building rapport', 'Connecting with youth', 'Enhancing the teachable moment' and 'Building relational health'. (57) These factors were highlighted in many of our stakeholder interviews and in the UK are important facilitators for all CYP. However, the ongoing challenge for UK A&E Navigators, irrespective of their own race, ethnicity or cultural background, is to understand how to build rapport and connect to CYP who face significant individual and structural challenges.

There are many frameworks to support building race equity into routine practice. A key report from Massachusetts outlined how they approached rising levels of gun violence by promoting race equity at the individual, agency and community levels. (Figure 8.2 (58). This framework can help individual A&E Navigators and services understand the wider scope of factors driving violence in CYP. This framework further supports the wide range of support and services that A&E Navigators services in the UK currently offer, including support with housing, education and employment.

Figure 9-2 What drives youth violence and its disproportionate impact on communities of colour? A report from Massachusetts Department for Public Health



Whilst race equity should be a key consideration for all services, in our stakeholder interviews, many were keen to recognise the impact of intersectionality and in particular social deprivation, with some CYP experiencing poorer outcomes due to the added impact of race on those CYP from deprived areas.

We noted that while most A&E Navigator services had policies relating to race equity (table 5.12), some of which related to their staff teams in terms of equality and diversity in terms of recruitment, only 50% of the services collected information on the ethnic background of their patientsanalysed differences in engagement and outcomes by patients' ethnicity (table 5.13). Outcome data collection is a very challenging area for A&E Navigator services. Understanding what data items are required, linking datasets and ensuring data quality is high is likely to be a key operational challenge. Whilst the collection of ethnicity/race data is a key data item, services should consider the idea of "conceptually thoughtful" data collection that aims to understand the root cause of racial health inequities. (59)

Practically this means rather than collecting race and ethnicity data solely for the purpose of reporting engagement and attrition rates (by ethnicity/race), services could adopt a conceptually thoughtful approach that seeks to understand the structural and systemic factors contributing to disparities in service use. This would involve not only capturing demographic information but also engaging with patients and communities to explore barriers to engagement, reasons for disengagement, and experiences of care that may differ by racial or

ethnic background. Such data should be linked with contextual factors—such as access, trust, and cultural safety—and interpreted in partnership with those affected. This deeper, more reflective approach could ensure data collection is not merely procedural but is instead used to inform meaningful action to advance racial equity and improve outcomes.

As A&E Navigator services span across a wide age range, from pre-teens to those in their 20s and 30s, there needs to be a conscious and continuous effort to avoid the adultification of CYP, especially Black CYP, who are most likely to experience adultification. (60) Adultification can be defined as:

'The concept of adultification is when notions of innocence and vulnerability are not afforded to certain children. This is determined by people and institutions who hold power over them. When adultification occurs outside of the home it is always founded within discrimination and bias. There are various definitions of adultification, all relate to a child's personal characteristics, socio-economic influences and/or lived experiences. Regardless of the context in which adultification take place, the impact results in children's rights being either diminished or not upheld.' (60)

It is as prevalent in males (boys) as for females (girls). (61)

In cases of CYP attending as victims of violence, often in the presence of police and in a heightened emotional state due to the severity of the incident they have just been a victim of, adultification can easily occur. In their advocacy role, A&E Navigators may be well placed to understand this phenomenon and hold clinical staff to account when this occurs.

A+E Navigators are likely witnesses to the impact and results of race inequity more than most professional groups. When a CYP presents to hospital after an injury secondary to violence, they are witnesses to the structural inequities that led to that point. Navigators will also be active witnesses to the way that health, police and other statutory services engage with that CYP. Moving forward, as race equity becomes a more considered part of how all services work, Navigators and CYP will have key insights into how services can best support CYP from Black and ethnic minority backgrounds in the future.

10. Appendix 1: List of A&E Navigator sites included in reports from the literature review between 2021-2024

	Hospital
1	Alder Hey Children's Hospital – Liverpool
2	Royal Liverpool Hospital – Liverpool
3	Aintree Hospital – Liverpool
4	Royal Manchester Children's Hospital – Manchester
5	Manchester Royal Infirmary – Manchester
6	Salford Royal – Salford
7	Royal Bolton Hospital – Bolton
8	Royal Preston Hospital – Preston
9	Royal Blackburn Teaching Hospital – Blackburn
10	Burnley General Teaching Hospital – Burnley
11	Accrington Victoria Community Hospital – Accrington
12	Blackpool Victoria Hospital – Blackpool (not evaluated)
13	Lancaster Hospital – Lancaster (not evaluated)
14	Queen Elizabeth Hospital – Birmingham
15	Heartlands Hospital – Birmingham
16	Birmingham Children's Hospital – Birmingham
17	Queen's Medical Centre – Nottingham
18	King's Mill Hospital – Sutton-in-Ashfield
19	St Mary's Hospital – Paddington
20	University Hospital Lewisham – Lewisham
21	Queen Elizabeth Hospital (Woolwich) – Woolwich
22	St Thomas' Hospital – Westminster
23	Croydon University Hospital – Croydon
24	Newham University Hospital – Newham
25	The Whittington Hospital – Islington
26	North Middlesex University Hospital – Edmonton
27	University College London Hospital – Euston
28	The John Radcliffe Hospital – Oxford
29	The Horton General Hospital – Banbury
30	Royal Berkshire Hospital – Reading
31	Wexham Park Hospital – Slough
32	Milton Keynes University Hospital – Milton Keynes
33	Stoke Mandeville Hospital – Aylesbury
34	Leeds Teaching Hospitals NHS Trust – Leeds
35	Bradford Teaching Hospitals NHS Foundation Trust – Bradford
36	Royal Alexandra Children's Hospital – Brighton
37	University Hospital of Wales – Cardiff
38	Morriston Hospital – Swansea
39	Neath Port Talbot Hospital – Neath

11. Appendix 2: List of mapped A&E Navigator sites as of March 2025

	Hospital/A&E		Hospital/A&E
1	Basildon University Hospital	39	Royal Blackburn Hospital
2	Basingstoke and North Hampshire Hospital	40	Royal Bolton Hospital
3	Bedford Hospital South Wing	41	Royal Hampshire County Hospital
4	Blackpool Victoria Hospital	42	Royal Lancaster Infirmary
5	Bradford Royal Infirmary	43	Royal Preston Hospital
6	Calderdale Royal Hospital, Halifax	44	Russell's Hall
7	Croydon University Hospital	45	Salford Royal
8	Cumberland Infirmary	46	Scunthorpe General Hospital
9	Dewsbury and District Hospital	47	Sheffield Children's Hospital
10	Diana Princess of Wales, Grimsby	48	Southampton General Hospital
11	East Surrey Hospital	49	Southend Hospital
12	Epsom Hospital	50	St George's Hospital (London)
13	Good Hope Hospital	51	St Helier Hospital
14	Heartlands Hospital	52	St James's Hospital
15	Homerton University Hospital	53	St Mary's Hospital, London
16	Huddersfield Royal Infirmary	54	St Mary's, Isle of Wight
17	Hull Royal Infirmary	55	St Richard's Hospital
18	King's College Hospital	56	St Thomas'
19	Leeds General Infirmary	57	Stoke Mandeville Hospital
20	Lister Hospital	58	Tameside Hospital
21	Luton and Dunstable Hospital	59	The Great Western Hospital
22	Manchester Royal Infirmary* (Adult's and Children's separate)	60	The James Cook University Hospital
23	Manor Hospital	61	The Royal London Hospital
24	Medway Maritime Hospital	62	The Whittington Health
25	Midlands Metropolitan	63	University College Hospital
26	Morriston Hospital	64	University Hospital (Coventry)
27	New Cross Hospital	65	University Hospital Lewisham
28	Newham General Hospital	66	University Hospital of Wales
29	North Middlesex University Hospital NHS Trust	67	Wexham Park Hospital
30	Northern General Hospital	68	William Harvey Hospital (Ashford)
31	Northwick Park	69	Wythenshawe Hospital
32	Pinderfields Hospital		**Funding cut during research (date)**
33	Queen Alexandra Hospital, Portsmouth* (Adult's and Children's separate)	70	Aintree University Hospital (April 2025)
34	Queen Elizabeth Hospital Birmingham	71	Horton General Hospital (April 2025)
35	Queen Elizabeth Hospital, London	72	Milton Keynes Hospital (April 2025)
36	Queen Elizabeth The Queen Mother Hospital	73	John Radcliffe Hospital (April 2025)
37	Rotherham Hospital	74	Whipps Cross University Hospital (unknown)
38	Royal Berkshire Hospital	*	*Sites are physically beside each other but separate EDs and navigators

12. Appendix 3: Result of complete case geospatial mapping

Due to a comprehensive search strategy for the mapping of A&E Navigator availability, the primary analysis assumes that sites not reporting Navigator presence have no service.

This Appendix, a complete-case analysis, reports results restricted to only those sites reporting the presence or absence of A&E Navigator services. While this analysis demonstrates some variation from the primary analysis presented within the main text, there is no change to the direction or meaning magnitude of the associations demonstrated.

Figure 12-1 A&E Navigator services, including sites where no data was provided from any source

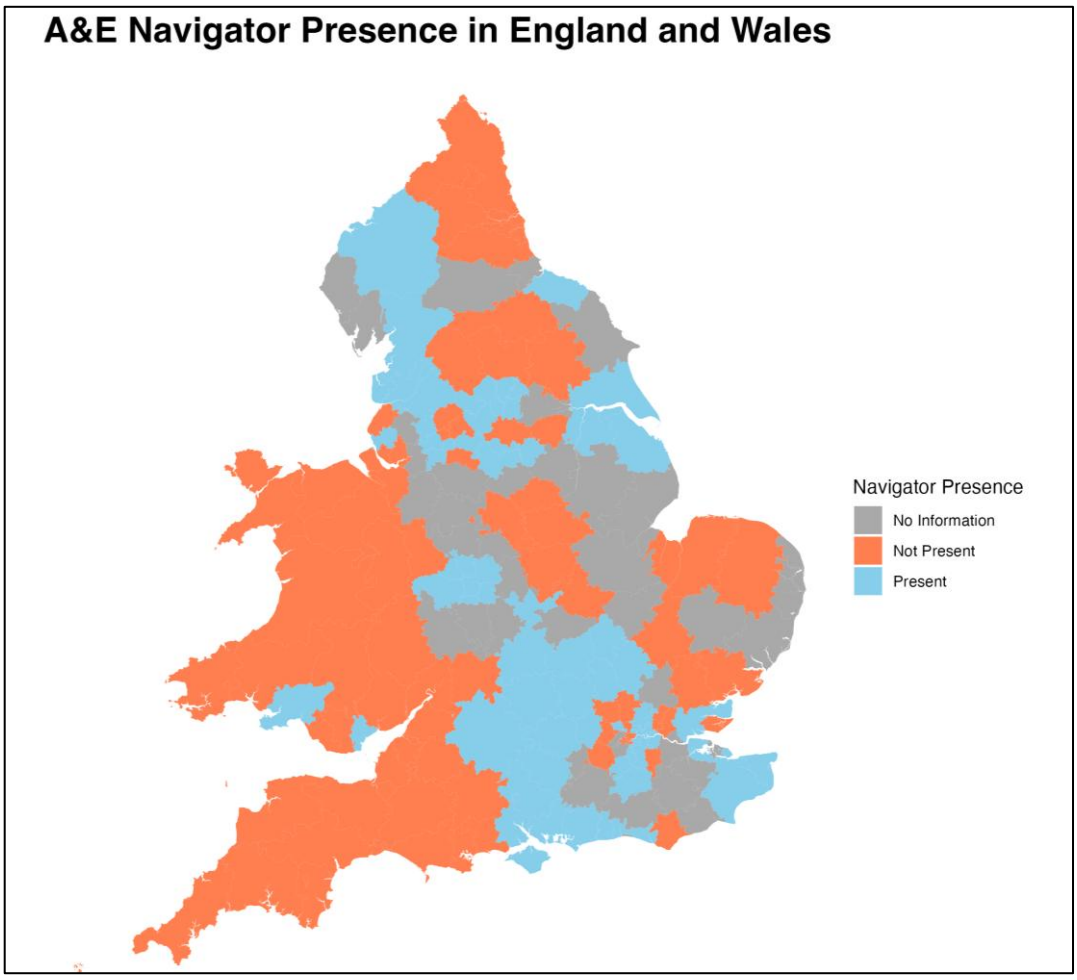


Table 12-1 Univariable logistic regression for presence of A&E Navigator for each explanatory variable for the secondary analysis (omitting non-responding EDs)

Characteristic	OR (95% confidence interval)
Index of Multiple Deprivation (IMD)[1]	0.95 (0.91, 1.00)
IMD crime domain[1]	0.91 (0.86, 0.96)
Crime rate per 100,000 population	1.06 (1.02, 1.11)
Violence rate per 100,000 population	1.04 (1.00, 1.08)

Notes: where not already in deciles, each variable was categorised into deciles so that odds ratios were on the same scale (i.e. per 1 decile increment).
Decile 1 = most deprived, decile 10 = least deprived, so OR is for increasing deprivation.

Table 12-2 Summary characteristics of modelled catchment areas for sites with and without A&E Navigator presence for the secondary analysis (omitting non-responding EDs).

Characteristic	**Overall** N = 149[1]		**Not Present** N = 75[1]	**Present** N = 74[1]
Population-weighted IMD Decile	5.43 (4.47, 6.21)		5.67 (4.76, 6.43)	4.98 (4.14, 6.03)
Population-weighted Crime IMD Decile	5.42 (4.16, 6.59)		6.00 (4.75, 7.20)	4.86 (3.80, 5.91)
Total Population	303,535 (223,651, 407,819)		282,406 (203,049, 368,808)	327,272 (229,261, 429,152)
Total Population Under 16	59,031 (41,357, 78,701)		54,744 (36,834, 73,928)	64,024 (48,432, 87,717)
Median IMD Decile	5.00 (4.00, 7.00)		6.00 (4.00, 7.00)	5.00 (4.00, 6.00)
Median Crime IMD Decile	5.00 (4.00, 7.00)		6.00 (5.00, 8.00)	5.00 (4.00, 6.00)
Annual Crime per 100 Population	9.02 (7.41, 10.90)		8.45 (7.07, 9.91)	9.93 (7.95, 11.40)
Unknown Annual Crime	12		5	7
Annual Violent Crime per 100 Population	3.15 (2.55, 3.84)		3.07 (2.49, 3.53)	3.34 (2.60, 4.06)
Unknown Annual Violent Crime	12		5	7
Ethnic Diversity (as Percentage White Population)	92 (81, 97)		96 (89, 98)	86 (71, 94)
Major Trauma Centre	26 (100%)	7 (29.6%)	19 (70.4%)	
Trauma Unit/Local Emergency Hospital	123 (100%)	68 (55.3%)	55 (44.7%)	

IMD – Index of Multiple Deprivation; IQR – Interquartile Range

Table 12-3 Univariable logistic regression for presence of Navigator for each explanatory variable for the secondary analysis (omitting non-responding EDs).

Characteristic	**Odds Ratio (95% Confidence Interval) for Navigator Presence**

Population-weighted mean IMD decile (each increment less deprived)	0.76 (0.58-0.98)
Population-weighted mean crime domain IMD decile (each increment less deprived)	0.64 (0.50-0.80)
Annual crime per 100 (2024)	1.18 (1.05-1.36)
Annual violent crime per 100 (2024)	1.72 (1.16-2.62)
Trauma-receiving Designation	
Major Trauma Centre	Reference
Trauma Unit/Local Emergency Hospital	0.30 (0.11-0.73)

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