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LANCASHIRE VIOLENCE REDUCTION NETWORK

Lancaster University

An evaluation of the Lancashire Violence Reduction Network: Emergency Department Navigators

Final Report

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Disclaimer

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Executive Summary

This evaluation aimed to explore how the Emergency Department (ED) Navigators programme has been implemented in two hospital trusts in Lancashire: Lancashire Teaching Hospitals NHS Foundation (Royal Preston Hospital) and East Lancashire Hospital Trust (Royal Blackburn Teaching Hospital, Burnley General Teaching Hospital, and Accrington Victoria Community Hospital). Taking a mixed-methods approach, a total of 15 interviews were conducted with the ED Navigators and the staff that work with/refer into the ED Navigators programme. Regularly collected monitoring data collected by the Navigators was also analysed to further contextualise the interview findings. Key findings from the evaluation for each trust are outlined below, highlighting similarities and differences of the two programmes.

Participants from RPH had a good understanding of the programme purpose and reach, however the monitoring data included individuals outside of the intended programme scope. A number of benefits to patients, patient families, and staff were highlighted including emphasising patient voice and providing a support system for families. Participants also highlighted the value added to the programme by both the healthcare setting, and the trauma-informed approach. Raising awareness of the programme and forming staff relationships were identified as important facets of programme adoption. Creating links with community agencies and external services was viewed as a vital element of the programme, as well as the ability to adapt patient care on a case-by-case basis. However, navigating the role's 'fit' into an existing team, increasing demand on the programme, and long waiting lists for some community services posed adoption and implementation difficulties. On a wider scale, the programme was thought to have better institutionalised trauma-informed working into the hospital.

Participants from ELHT has a good overall understanding of the programme purpose and reach, however there was some confusion expressed around what the overall role of the ED Navigator was trying to achieve. Participants discussed patient and staff benefits, such as providing targeted patient support and sharing best practice with other staff members. The healthcare setting of the programme was seen to add value in addressing wider, health based issues surrounding a patient's admission. Raising awareness of the programme, forming staff relationships, and the use of 'trial and error' were important factors in adoption. Difficulties of adoption were mentioned regarding navigating the role's 'fit' into an existing team, and the ED Navigators already being known to staff in a clinical capacity. Discussions around the use of a nursing led screening model provided mixed opinions, where some participants valued the ability to 'safety net' patients and others felt the process to be time-consuming. On a wider level, the programme was thought to have better institutionalised trauma-informed working in the hospital.

Both trusts identified patient relationships, staff relationships, and community relationships as key factors in in the successful adoption and implementation of the programme. They both also considered the demand of the programme, and the want for more ED Navigators in post was expressed by ED Navigators and staff. The main difference identified was the difference in implementation models of the two trusts,

with RPH utilising a non-nurse led referral model and ELHT utilising a nurse led screening model. Whilst all respondents at RPH were happy with the existing programme model, the model at ELHT was questioned both in terms of the need for a Navigator to have a clinical background, and the need to screen all patient admissions.

Following the evaluation, the authors make the following recommendations.

- A consideration of how patient needs are prioritised, and how demand for the service is managed by the ED Navigators.
- An evaluation of how the duties of the ED Navigators (e.g. awareness raising and information sharing about the programme, collating sources of referral services/agencies) are balanced with direct patient contact.
- A consideration of how shift patterns are designed for ED Navigators to ensure that patient needs are met.
- A consideration of the number of ED Navigators assigned per trust. An increase in the number of Navigators could increase the number of patients contacted, diversify shift patterns for evening/weekend working, and/or increase capacity for researching referral services/agencies.
- Following on from the work of the ED Navigators at the time of interview, a development of the feedback process for patients who engage with the ED Navigators programme. This could include data collected prior to and post programme engagement to improve knowledge around patient outcomes, patient experiences, and the need for any improvements to the service.

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List of acronyms

ED - Emergency Department

ELHT – East Lancashire Hospital Trust

HO – Home Office

LVRN – Lancashire Violence Reduction Network

RPH – Royal Preston Hospital

TIIG – Trauma and Injury Intelligence Group

VRU – Violence Reduction Unit

Introduction

Background

In July 2019, the Government announced Home Office funding to assist 18 police force areas to set up Violence Reduction Units (VRUs). The Violence Reduction Networks commit to a whole system public health approach to prevention. This involves applying concepts borrowed from established public health practices that include: conducting strategic needs assessments; establishing a local problem profile; multi agency work (including blue light services, social services, probation, youth work, local authorities); data sharing for intelligence gathering and evaluation (Home Office, 2020). Lancashire was selected as one of the 18 areas and subsequent needs assessment carried out by the newly formed Lancashire Violence Reduction Network (LVRN).

The LVRN aims to take a trauma-informed approach to all of their work. The key goal of trauma-informed practice is to raise awareness among all staff about the wide impact of trauma on the causes and effects of violent behaviour and to prevent the re-traumatisation of clients engaging with services that are meant to support and assist healing (LVRN, 2020a).

Involving the NHS is part of the LVRN's whole systems approach and in Lancashire the health services-related intervention currently being piloted in hospitals is the Emergency Department (ED) Navigator role.

The ED Navigator role is delivered by the LVRN, and the main aim of the role is to identify and engage with patients 10 to 25 years old, who have injuries consistent with involvement in violent crime in a non-judgemental way, and to intervene as close to the time of the violent incident as possible (type of injury and age are the two eligibility criteria for inclusion in the programme). The role is about prevention and using the knowledge we have in public health and trauma informed approaches to understand why people commit violence, helping them to navigate away from violence towards a more positive lifestyle (LVRN, 2020b).

The LVRN ED Navigators model prioritises anyone aged 25 and under, as per the Home Office success measures, however there is flexibility to support older individuals. This correlates with assault attendance data (January 2016 to June 2023) from the Trauma and Injury Intelligence Group (TIIG) to all Lancashire hospitals, where male attendees were most commonly 20-24 years old, and female attendees 25-29 years old.

The aims are to refer patients appropriately to relevant services and to support engagement with these services. The ED Navigator role is currently operational in Blackpool Teaching Hospitals NHS Foundation Trust (Blackpool Victoria Hospital), Lancashire Teaching Hospitals NHS Foundation Trust (Royal Preston Hospital), East Lancashire Hospital Trust and Lancaster Hospital emergency departments. Staff involved in treating patients via “Go to Doc” urgent care and staff who work on other wards can also signpost patients to ED Navigators.

Aim

The aim of this evaluation is to explore how two of the sites (Lancashire Teaching Hospitals NHS Foundation Trust and East Lancashire Hospital Trust) are implementing the programme and the impact it has had to date. At the time of the evaluation, the ED Navigators programmes in both Blackpool Victoria Hospital and Lancaster Hospital were still in the early stages of development and implementation, and therefore have not been included in the evaluation. However, conversations were had with the ED Navigators in both hospitals to provide further context for future evaluation work. This can be found at the end of the report.

To help further contextualise the findings of the evaluation, below are two short paragraphs for each trust that describe the models of each ED Navigator programme.

Royal Preston Hospital (RPH)

RPH has one, full time ED Navigator in post that works the core hours of 9am-5pm Monday to Friday, at a Band 7 (salary range £46,148 – 52,809). The model is referral based and the ED Navigator does not have a clinical background. Staff members can fill in a referral form for patients, or they can more informally reach out to the ED Navigator directly. This can be via e-mail, phone, or in passing conversations. Patients that fit the eligibility criteria will then be contacted by the Navigator. The ED Navigator regularly raises awareness of the programme within RPH via face-to-face contact with staff, and wider in the local community.

East Lancashire Hospital Trust (ELHT)

ELHT has two ED Navigators in post, one full time and one part time (0.5 FTE at 22.5 hours a week). The FTE salary is within a Band 7 (salary range £46,148 – 52,809). The core hours for the full-time member of staff are 10am-6pm, and the part-time hours are 8am-4pm. The working pattern for the full-time Navigator is Monday to Friday. The working pattern for the part-time Navigator varies in terms of days, but will generally include a Monday due to how busy the day usually is.

The model is nurse-led screening model, with both ED Navigators coming from a clinical nursing background. Admissions from the previous 24 hours are screened by the ED Navigators to find patients that fit the eligibility criteria for the programme. Other hospital staff have the ability to submit a referral to the Navigators, however this is extremely infrequent.

Methods and Analysis

The evaluation adopted a mixed methods approach. This included using analysing anonymised monitoring framework data routinely collected by the ED Navigators and conducting interviews with both ED Navigators, and staff who work with/refer into the programme.

The routinely collected data was gather by the ED Navigators and then anonymised by the data controller. Descriptive statistics were performed on this data using Microsoft Excel.

For the interviews, the topic guides and analysis were informed by implementation and evaluation theories, and the logic models developed for the ED Navigator programmes. All interviews took place individually via Microsoft Teams. All interviews were transcribed by AM and then uploaded onto NVivo, where they were analysed using a framework that had been developed prior to the interviews. Due to the small sample size, the quotations are not referenced beyond the site they align to, in order to protect anonymity of participants.

Ethics

NHS research ethics approval was not needed for this evaluation. The evaluation was authorised at each trust. Lancashire Teaching Hospitals NHS Trust approved the evaluation on 15th May 2024 and East Lancashire NHS Trust approved the evaluation on 31st May 2024.

Findings

These findings represent perspectives on the ED Navigators programme from fifteen members of staff, and the analysis of monitoring framework data routinely collected by the ED Navigators. Findings have been separated per hospital trust, to therefore compare and contrast participant perspectives both within each trust and against each trust.

For Lancashire Teaching Hospitals NHS Foundations Trust (Royal Preston Hospital), nine members of staff were interviewed (see Table One below). Monitoring framework data was analysed from September 2023 to June 2024. For East Lancashire Hospital Trust, six members of staff were interviewed. Monitoring framework data was analysed from January to June 2024. The timelines for the monitoring data differ between sites due to different start dates of when the trusts began operating a localised programme model. The framework data collected by the ED Navigators is used to help identify impact and outcomes of the programme. Individuals that have engaged, have disengaged, or that have declined support from the ED Navigators are included in the framework data to provide an overall picture of those individuals contacted.

Participant One	Staff member from Royal Preston
Participant Two	Staff member from Royal Preston
Participant Three	Staff member from Royal Preston
Participant Four	Staff member from Royal Preston
Participant Five	Staff member from Royal Preston
Participant Six	Staff member from Royal Preston
Participant Seven	Staff member from Royal Preston
Participant Eight	Staff member from Royal Preston
Participant Nine	Staff member from Royal Preston
Participant Ten	Staff member from East Lancashire
Participant Eleven	Staff member from East Lancashire
Participant Twelve	Staff member from East Lancashire
Participant Thirteen	Staff member from East Lancashire
Participant Fourteen	Staff member from East Lancashire
Participant Fifteen	Staff member from East Lancashire

Table One – Participant overview

Findings have been analysed and structured as per the RE-AIM framework. The RE-AIM framework allows for evaluation of health and public health settings through five core components (RE-AIM, 2024). For each section of the RE-AIM framework, interview findings will firstly be discussed and where appropriate, analysis of the monitoring framework data will follow. The five components are:

- **Reach –** Who is intended to benefit from the ED Navigators programme, and who participates/is exposed to the programme.
- **Effectiveness –** What are the most important benefits that the ED Navigators programme is trying to achieve.
- **Adoption** – What did/did not facilitate adoption of the ED Navigators programme.

- **Implementation** – How is the programme being delivered, and what adaptations have been made.
- **Maintenance** – How has the programme become institutionalised, and what are the long-term effects of the programme.

Royal Preston Hospital (RPH)

Reach

This section covers findings in relation to how participants defined who the ED Navigators programme is designed for, and who participates in the ED Navigators programme. Questioning was broad, to allow participants to share their own understandings of the aim of the ED Navigators programme and therefore patients that access the service. Responses regarding the reach of the programme generally considered two core elements; the injury presented by the patient, and the age of the patient. Some respondents highlighted 'official' guidance of programme reach for example shared by the Violence Reduction Unit (VRN) or the Home Office:

> *'to work with anybody from the ages of 10 to 25. That is what I believe the Home Office identified as key areas of hotspots and the age…. (to) work with anybody that comes through ED or on the ward that have made a disclosure of any serious violence'* (Participant One)

Other respondents defined reach of the programme in a much broader sense, capturing the essence of the ED Navigator work but missing key details pertaining to scope:

> *'it's making sure that anybody who's vulnerable is supported to be in a less vulnerable place, and not set out into the world without any kind of backup'* (Participant Four).
>
> *'to reduce hospital admissions for violent crimes to keep people safer'* (Participant Five).
>
> *'To kind of join in different multi agencies to kind of put timelines in place and ensure that everybody's assisting in helping the patient and the families…I'm sure there's loads to it'* (Participant Eight).

In terms of age, there was seen to be some flexibility in the maximum limit of patients referred and/or included in the programme. It was recognised that the Home Office (HO) 'hot spot' age range was 10 to 25, but the '*cut off point would be somebody 29 going into their 30s'* (Participant One). This was dependent on the discretion of the Navigator, their current workload, and their availability, i.e. if they were already 'inundated' with patients in the 10 to 25 age group. However, some confusion was expressed by the ED Navigator here. Although the HO collect data for those patients aged over 25, there was uncertainty from the Navigator surrounding if this work is 'picked up' and recognised by the HO. There was also some uncertainty around age limits in terms of referral to the programme:

> *'The age categories can be a bit, were initially a bit confusing in all honesty, and initially it was a higher category of age…It's been dropped to 25 I think…the age categories just really confusing because you would think it goes up to 30'* (Participant Six).

Despite this, participants shared how some form of care would still be administered by the Navigator if a patient was deemed ineligible (regarding age or otherwise) for the programme or the Navigator did not have capacity. This included signposting to other services, advising the adult safeguarding team on how to take the lead, and where needed contacting the police:

> *'We can't simply turn a blind eye just because they're over 25'* (Participant One).

Analysis of the monitoring framework data collected by the ED Navigator indicated a slightly different idea of reach to that described by the interview participants. From September 2023 to June 2024, a total of 142 attendees were included in the data, i.e. contacted by the ED Navigator. The primary reason for initial programme engagement was criminality at 42% (n=60), followed by mental health at 23% (n=33).

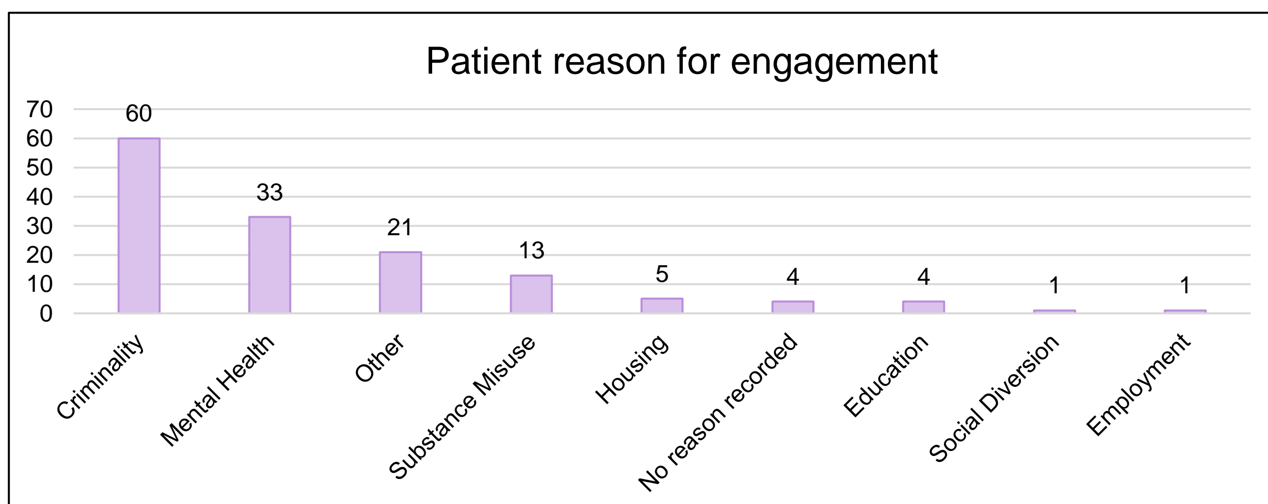

Figure One – Patient reason for engagement

Of the 142, a total of 72% (n=102) engaged with the ED Navigator programme. 14% (n=20) of attendees included in the data did not have information on whether or not engagement was made with the programme. Engagement is not necessarily defined as a referral being made, but some form of support/contact being administered by the Navigator.

In terms of attendee characteristics, 57% of all attendees (engaged and non-engaged) were male (n=81) and 42% were female (n=59); the gender/sex of two attendees was not recorded in the data. The ages of patients in part reflected comments made in the interviews, with those aged 15 to 19 making up the largest proportion at 37% (n=53). However, 18% (n=25) were aged 30 and over. Of this 25,

72% engaged with the ED Navigators programme. The youngest patient included in the framework was 11, the oldest was 46, and age was not recorded for two patients.

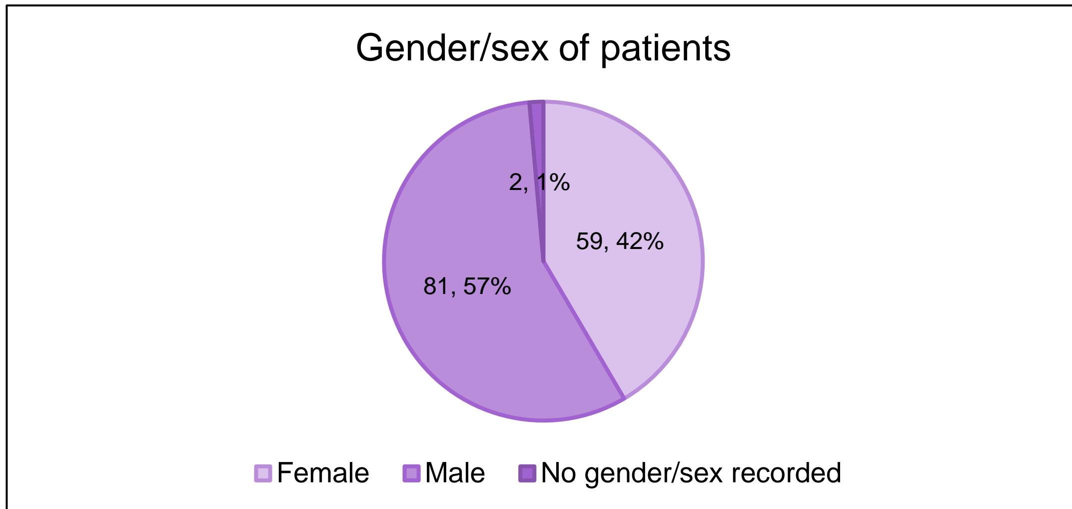

Figure Two – Gender/sex of patients

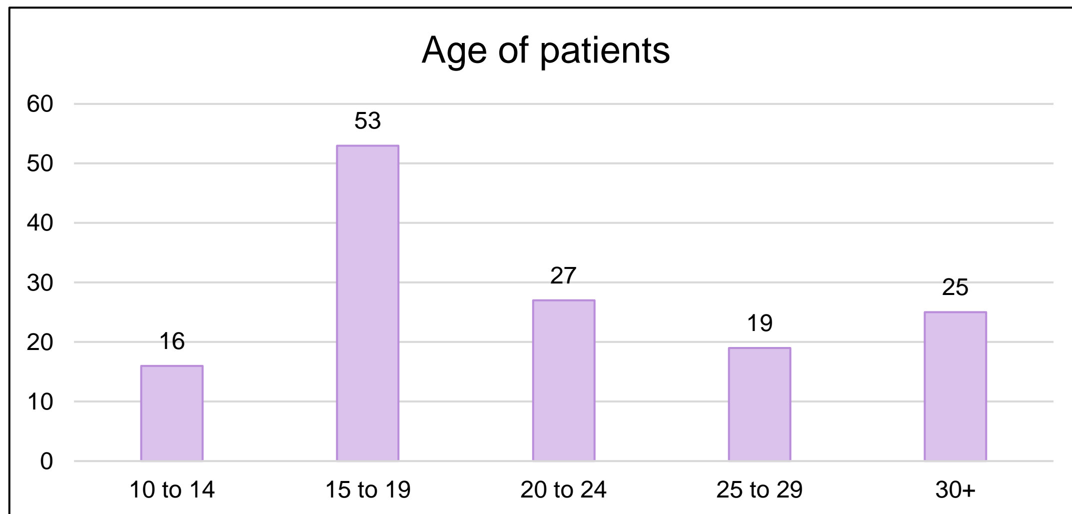

Figure Three – Age of patients

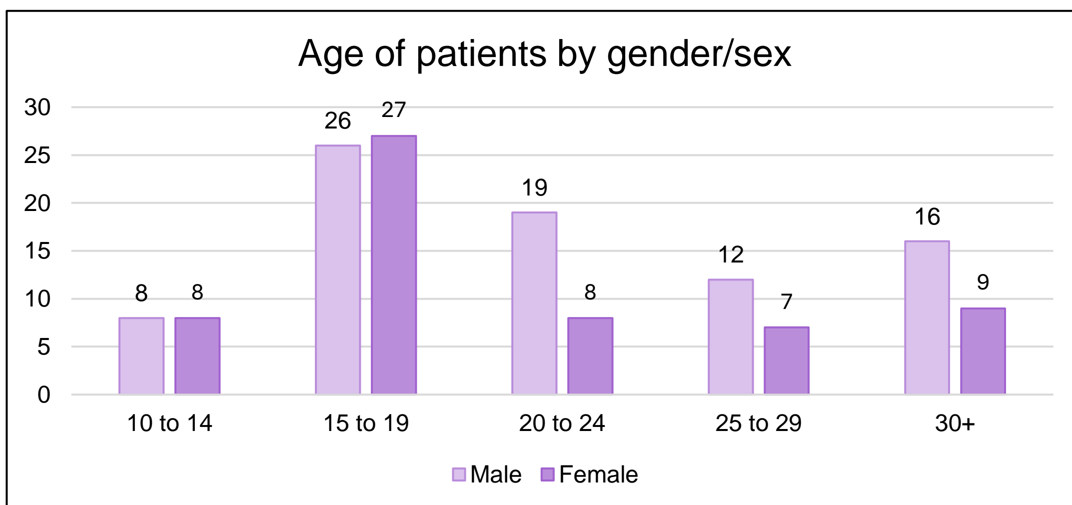

Figure Four – Age of patients by gender/sex

Effectiveness

This section discusses findings in relation to the benefits of the ED Navigators programme, and the extent to which the programme is seen as likely to achieve its purpose. Again, questioning followed the participants' ideas of what benefits the programme achieves. Aside from benefits directly related to patients participants indicated both great benefits to other individuals, and the added benefit of the approach adopted by the programme.

Patient benefits

Participants agreed that there was a definitive benefit of the programme of patients. This included reassuring patients they were cared for, the voice of the child was being acknowledged, and that in the longer term, re-attendance rates could decrease. References were also made to the role of the ED Navigator in their multi-agency working with specific services, for example liaising with schools to try and prevent exclusions for young people. This in turn established a better link with patients and their different needs:

> *'It's showing the child, it's showing the family that somebody is really interested and really bothered and is, you know, sitting there with you trying to* help' (Participant Two).
>
> '*This is one of the first services I've seen in my career that pulls everyone together*' (Participant Three).
>
> *'readmission rates are probably the biggest thing to look at (in terms of outcomes)…if somebody's readmitted two or three times, the next time it usually that it ends in a death, and they won't be leaving the hospital* (Participant Five).

Of those engaged with the ED Navigator programme (n=102), 61% of these individuals (n=62) were referred elsewhere. There were also 11 referrals made for non-engaged patients and 6 referrals made where the engagement status was not recorded. A total of 79 patients therefore were given a referral.

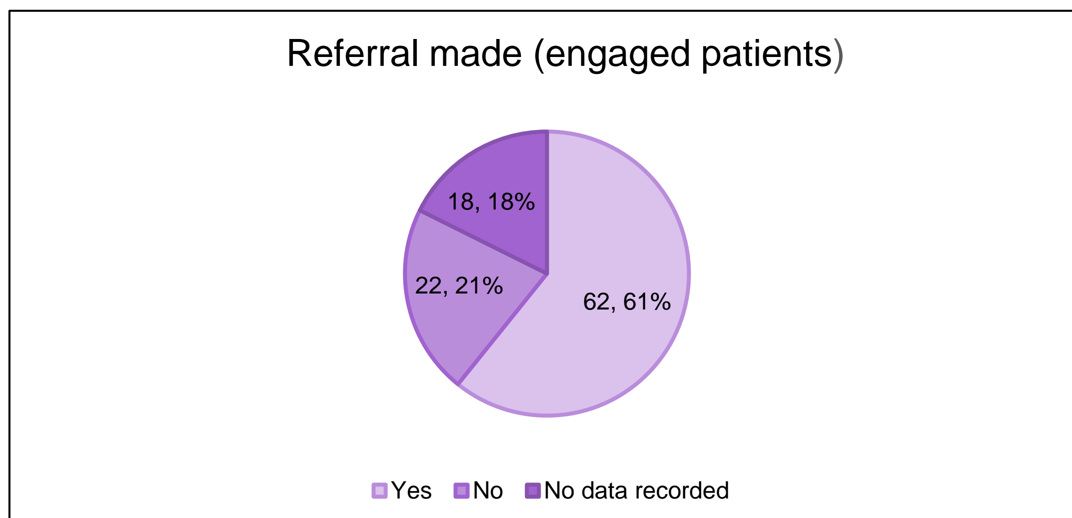

Figure Five – Referral made (engaged patients)

Referrals for engaged patients were most commonly made for mental health (n=28) followed by other (n=12), with reason for referral not given for 3 engaged individuals. Within the other category, reasons given included housing, counselling, and safety planning. Examples of referral services included LVS (n=13), Champions (n=12), Trust House (n=7) and CAHMS (n=4). A referral attendance rate of 94% (n=58) was documented.

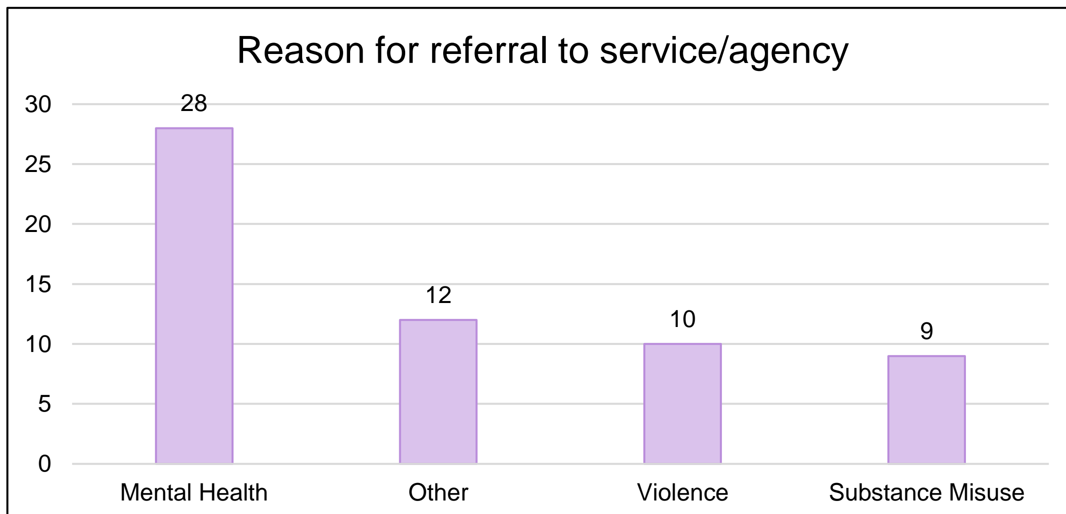

Figure Six – Reason for referral to service/agency (engaged patients)

The informality of the role was also seen to be a benefit of the programme, and therefore a benefit to patient care. Here, the way in which the ED Navigator communicates to patients was appreciated, making the work done feel very human and the service feel non-threatening. This was also seen to be important when explaining concepts about their care to patients in an easy-to follow manner:

> *'You know, as clinicians and nurses and doctors, we all have quite a formal, structured way of doing it and often patients that we're dealing with in these circumstances don't relate to that and it needs to be somebody that can get often difficult conversations done in a very relaxed way, a non-threatening way to them'* (Participant Three).

> *'The ED Navigator can explain sort of a lot more of what happens in terms of police investigation, community support. So I think that they do have a massive impact on patients'* (Participant Five).

> *'I think that they (patients) feel safe. They've got a safe space to talk and a safe space to talk without judgement so that even if they decide that they're going to return back to the gang, they still know at some point there's a different path they can take'* (Participant Six).

More generally, analysis of the monitoring framework data captured 67% of engaged individuals having an improved outcome due to the work of the programme. The most common improved outcome was criminality (n=32) followed by mental health (n=19).

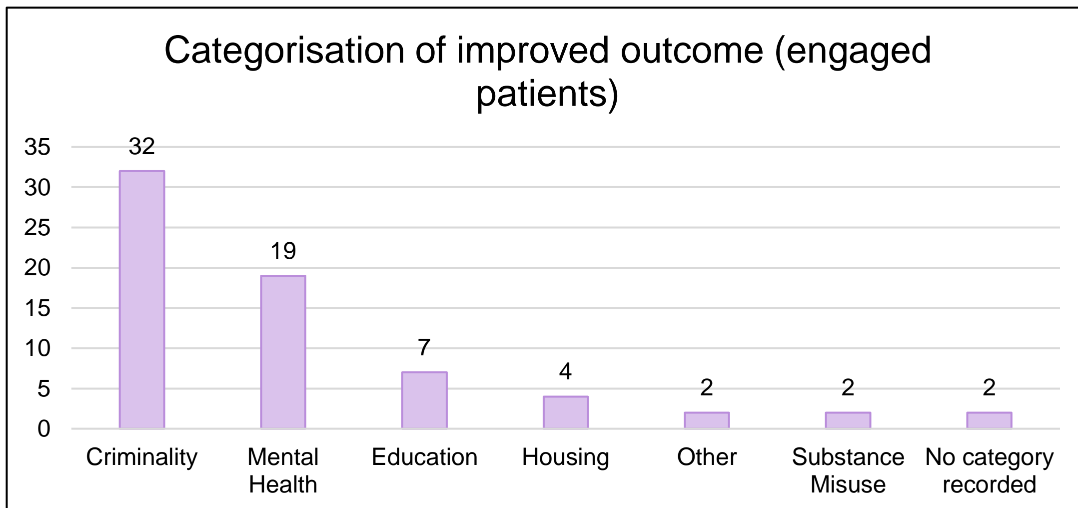

Figure Seven – Categories of improved outcome (engaged patients)

Specific details shared on improved outcomes were wide ranging dependent on the needs of the individual, and often included an indication of multiple referrals being made and/or avenues of support. These also included where certain topics were explained by the Navigator such as police processes. It should be noted however that outcomes as described in the framework were action-based, i.e. a referral being made, or advice being shared.
Examples of improved outcomes included:

> *'Discussed safety planning, referral to Champions, LVS (Lancaster Victim Services), Housing'*

> *'Discussed safety planning, MARAC process, IDVA support, Police report and process of CJS'*

> *'Provided advise on safety planning, completed safeguarding alert with ASC due to additional vulnerabilities, liaised with police, provided supporting housing letter'*

Families of patients

Participants also shared instances of programme benefit to patient families. This aspect of the programme was integrated with the trauma-informed approach and looking at a situation holistically. Examples of referrals for patient parents and siblings were discussed, with the intention to look for the root cause of any issues. These included referrals to counselling services, liaising with occupational health, and explanations how certain criminal justice systems work such as the courts.

Feedback from families expressed feeling heard for the first time, building awareness around available support services, and being able to 'breathe':

> *'if they (the patient) have a diagnosis of ADHD or autism, a lot of the families are at the end of their tether or they're finding it really difficult'* (Participant One).

'*it is quite distressing for families to go through some of the things that they're going through'* (Participant Eight).

Staff benefits

Staff valued the programme for personal and job-related reasoning. It was felt that the role of the Navigator improved knowledge around patient outcomes, as they 'never get to hear the other side' (Participant One). This aspect of the programme held 'enormous appreciation' (Participant One) for staff, as well as the ability of the Navigator to go beyond scratching the surface, benefiting staff morale and ensuring A&E staff could focus on clinical duties. Feedback given by the ED Navigator on certain cases also made the work done by staff feel more worthwhile:

'it meant that the nurses could go 'That's OK. Somebody who knows what they're doing is taking control of the situation' (Participant Four).

'(The ED Navigator) can come in and bridge that gap, and try and get some assurances for them and try and get them the right support they need, and maybe ensure that they don't go back to the life that brought them into the hospital in the first place' (Participant Seven).

One participant also shared how the ED Navigator had helped them personally with issues concerning their child. The Navigator involved the police and the school to resolve the issue, which was seen as a preventative measure in avoiding the staff member taking time off work with stress.

Participants also valued that, due to the community work and links fostered by the ED Navigator, they too were able to learn about these and use where appropriate in their roles. This information is regularly shared in monthly safeguarding meetings. Linked here with the theme of maintenance, not only does this act as a benefit to staff, but also to the wider hospital trust in institutionalizing the work of and knowledge gained from the programme:

'*there is quite a lot of learning that happens subliminally when people are not even aware that they're learning…I'm sure a lot of collegues will be learning'* (Participant Seven).

Trauma-informed approach

The use of a trauma-informed approach was seen as an included benefit of the programme and an integral element of the work of the ED Navigator. This approach allowed the ability to '*look at the rippling pattern, the family, and the cause of the cause'* (Participant One). Participants also linked the benefit of the trauma informed-approach being utilised within a healthcare setting and the ability to look at the whole picture when assessing a patient. This sentiment reflects the benefits of the programme to patient networks, but also the important of professional curiosity in the role:

'It's just thinking wider… links with public health links with criminality because obviously what you see is not, it's not just the child something's happened to. There's a whole range of things going on' (Participant Two).

Benefit of healthcare setting

Some participants reflected on the healthcare setting and healthcare involvement as a benefit of the ED Navigators programme. The hospital was seen to be a safe environment where patients could more freely discuss their situation. In building a trusted relationship, the ED Navigator is able to come and speak directly to patients and gain permission to inform the police of an incident, something that participants acknowledged as an advantage:

> *'I think we see a lot in ED that probably doesn't get reported (to the police), and I think before we would be like 'Do we need to tell? Are we breaching data protection?' We're very nervous in health…And I think having the role bridges (the gap)'* (Participant Nine).

This is in turn helpful in gaining intelligence on violence, and mapping any trends:

> *'Because the hospital is seen as a place of safety, people probably let their guard and at the time they're in a position of vulnerability, they're looking up to professionals…young people open up about some of the challenges that has led them into the situation that had led them to come to hospital'* (Participant Seven).

> *'most things that happen in the community, they end up in A&E... You can measure the temperature of what's happening in society, in the community by just what's happening in your A&E'* (Participant Seven).

Adoption

This section discusses responses on the adoption of the ED Navigator programme. This includes how staff responded to the adoption of the programme, important factors in facilitating successful adoptions, and any barriers therefore faced in adopting the programme.

Raising awareness

An important aspect of adoption frequently mentioned was raising awareness in the trust on the ED Navigator programme, where '*The first month was about promoting the service, raising the awareness'* (Participant One). Communication surrounding the programme aims of the programme was seen to be vital, particularly in ED where the department is large, busy, and experiences a high staff turnover. The success of this was slightly mixed amongst respondents. The majority believed that awareness of the ED Navigators programme was high, but some participants felt more could have *been/could still be done:*

> *'it was just establishing that getting it at the forefront of people's minds, but actually it hasn't taken that long'* (Participant Three).

> *'I think we could have done with a lot more communication. Like from a trust wide point of view, advertise the role…get the ward managers or directorate managers together'* (Participant Six).

'I don't think we were ever formally told. I'm sure management were but really, it's been kind of like a slow burn for me, like personally in my role' (Participant Eight).

There was also thought given to the title of the service, and that this may lead to confusion and missing coherence around what the programme does:

'The title ED Navigator can be misleading because, yes, the vast majority of people do come through ED but at the same time, they see patients around the hospital and I don't know, it sounds more like a character than a role…People didn't know through the hospital what the ED Navigator does was and quite often they would see it just isolated to ED' (Participant Six).

Relationships with staff

A good working relationship with staff was viewed as an important consideration in the adoption of the programme. This was referred to by some participants as somewhat of a continuing process:

'*I think there's a lot of work in trying to incorporate the role into the safeguarding team. Looking at how we incorporate into the policies and how we work together'(*Participant Two).

There was also a recognised collaborative approach between the ED Navigator and other safeguarding staff members, where specific cases could be discussed, and patient pathways considered. This was viewed positively staff:

'it's more of a multidisciplinary team. It's a collaborative approach and that's how it should work' (Participant Seven).

An acknowledged barrier to adoption however was ensuring that the 'fit' of the ED Navigator into the existing safeguarding team was right, and that professional responsibilities were clear. This stressed the important of raising awareness around the role to ensure all staff members are aware of the distinctions between an ED Navigator and other safeguarding collegues. A specific example of this was shared with a staff member sending an email enquiry to the safeguarding team that was not then passed onto the ED Navigator:

'(There has been an issue with) Maybe some kind of professionals feeling like they're toes are being stepped… So there has been a few issues with 'What's my job? What's the ED Navigators job?' (Participant Two)

'I think sometimes her own collegues and safeguarding can be a hindrance' (Participant Eight).

Aside from these issues, perspectives on the adoption of the ED Navigator role into the trust were very positive:

'it (the role) brings a massive addition to our team and someone that we ring for advice, someone that coordinates things for us. I do often feel we ring her about a child and say 'This has happened' and two weeks later, she'll come

> *back to me with 20 things that she's done and put in place for the child'* (Participant Three).

On a wider hospital and trust level, it was felt that the adoption of the programme was very smooth. This was due primarily to the work of the ED Navigator themselves in information sharing about the programme, and having a strong professional reputation within the trust.

The important of staff relationships also extends to ED staff, consultants, managers and nursing staff, where the daily visibility of the ED ensured that the programme was not forgotten about. Participants shared their appreciation of the face-to-face contact made with the ED Navigator. They make a point, particularly with ED, of 'going every day' to visit and talk with staff, maintaining awareness of the programme and an open line of communication. In this manner, informal conversations could also be had as to any practice improvements. This visibility extended outside of ED to other departments such as major trauma, critical care, and paediatrics:

> *'when people meet a child that fits that sort of ED Navigator criteria that could benefit from it, you instantly think 'Oh! This kid would be great (for the programme). I think with other services we don't always do that because it's not as personal'* (Participant Three).

Implementation

This section discusses responses focused around programme delivery. Emergent themes include how the programme is delivered, what is important in delivering the programme, and barriers that are faced. Overall, participants were not aware of any changes made to the programme since adoption and during implementation. The only change mentioned was by the ED Navigator, in their creation of the ED Navigator forum. The forum is shared by ED Navigators from ELHT as well as those from Merseyside and Leeds. Here, Navigators now have the opportunity going forwards to share best practice, discuss specific complex cases, and receive support from fellow ED Navigators.

Managing expectations

In terms of programme delivery, some participants did stress the importance of 'managing expectations' for ED Navigator patients and families. For example, the role of the Navigator could be to advise and provide information to schools, however ultimately it was the decision of the educator as to what steps should be taken. ED Navigators cannot *'wave a magic wand'* (Participant One) to resolve all issues that may be presented by a patient, therefore it was important that the remit of the programme be communicated to users:

> *'I think it's about managing expectations is the biggest one because once you bring the ED Navigator people think 'OK, you're gonna solve all the issues'…So it's about managing expectations, really being clear on what the role is, what the expectation is, when to get involved'* (Participant Seven).

Managing expectations was also mentioned in regard to the frequency of patient contact when engaging with the ED Navigator programme. Collected patient feedback demonstrated a want for weekly contact with the ED Navigator, however due to limited capacity, this not possible. Related to adoption and awareness raising for the programme, it was stressed that *'this is not an emergency service'* (Participant One).

Method of delivery: referral model

Although the programme has a referral form for staff to complete, participants shared how they also used more informal means to contact the ED Navigator. This included emails asking for a specific case to be reviewed, passing conversations in the department, and phone calls. It was agreed that this system works well, particularly for ED staff who are 'very pressurised' and may not always have the capacity to fill in a referral form:

> *'Sometimes staff are put off with referral forms because it's time consuming... we just send a quick e-mail, and it doesn't have to be formal'* (Participant Three).

However, it was felt that some staff members may not share this same working relationship with the ED Navigator, and may therefore not have the same level of knowledge regarding referrals:

> *'I think it (the referral process) could be better…I know there are referral forms, but I don't think they're probably as well known about'* (Participant Five).

Demand

Demand for the service is extremely high. The Navigator often works outside of their contracted hours (9-5pm) to ensure service delivery, at times staying until 11:30pm. It was felt that with RPH being the trauma-centre for Lancashire, having one ED Navigator was not sufficient. The support of safeguarding collegues did help to elevate some of this pressure, with a *'joint effort'* (Participant Three) amongst the team. However the general high level of demand on both the programme and the Navigator was recognised by participants:

> *'I do think that doing it solo probably is going to be quite an undertaking'* (Participant Nine).

Working with patients

It was stressed that the approach taken by the ED Navigator was different dependent on patient needs. Strategies for working with patients were done on a 'case by case' basis, however there were certain approaches that were employed consistently. This included a consideration of home dynamics, education (specifically for those aged 10 to 16), and where applicable identifying ADHD and/or autism diagnoses. A preference for face-to-face contact was also demonstrated from collected patient feedback. Reflected in the monitoring framework, 57% of programme participants (n=82) received face-to-face contact at time of admission, with a further 10% (n=15) face-to-face after attendance.

However, the ED Navigator does share their work mobile number with patients for contact. This in part was also due to the Navigator being the only person in post for RPH, but again managing expectations was prominent in creating a boundary and confirming to patients that the programme is a Monday to Friday, 9am to 5pm service.

The sometimes difficult nature of the ED Navigator role working with patients was mentioned by one participant. They referenced the welfare of the ED Navigator, noting that she informs a member of staff where she is going out in the community, or might meet in a communal place. It was suggested that having two people in the role may be beneficial here in terms of support, as Navigators would be able to make visits in pairs. Potential difficulties were also mentioned related to again to welfare but to the demand of the role. Flexible working patterns and ensuring the ED Navigator was support proved important.

When collecting feedback, the need for a more formalised method was shared. This would help standardise the process but also better collect information on programme impact, benefits and weaknesses. At the time of interview, the ED Navigator was designing a feedback sheet to be completed by patients and patient families. It was stressed however by the ED Navigator that current outcomes recorded in the monitoring framework are always asked directly of patients and families. Where collected, current patient feedback shared by participants was positive.

Working with community agencies and external services

Partnership collaboration with other community agencies was viewed as an integral aspect of programme delivery, as well as having knowledge of what agencies exist in the community; *'it's not a simple thing getting in contact with all these different people outside of the NHS'* (Participant Four). A specific example given was the work of the JTAI (Joint Targeted Area Inspection) report, and the outreach done with the Muslin Forum and BAME individuals in the community. Services/agencies mentioned by participants were wide ranging and included criminal justice agencies, mental health services, counselling services, housing, and drug and alcohol services:

> *'I think the community aspect goes hand in hand with the ED Navigator'* (Participant One).
>
> *'(The ED Navigator programme) definitely helps with relationships with police, because there's usually a big police presence and the ED Navigator does that negotiation'* (Participant Five).
>
> *'we've got those good links and good relationships with children's services so that they can go and do the home risk assessments and understand the child's circumstances…So you will need all those community partners, it's key'* (Participant Seven).

This partnership building was also acknowledged when discussing the recruitment and backgrounds of ED Navigators, with understanding the community, community demographics, and available services pivotal:

'I can go on the Internet and look for phone numbers (for support services)… and almost all of those numbers were dead… it's so important so have somebody who knows exactly, who knows what, who to contact out there in the world' (Participant Four).

'A counselling background, a youth workers background, community background. Somebody who's used to working with teenagers and families' (Participant Six).

When thinking then about an ED Navigator having a clinical background and/or knowledge of a clinical setting, this was not deemed a necessity but was seen by some to be a potential advantage, and others a potential disadvantage:

'I think narrowing the field (to a clinical nurse) is not a good thing because there's so many people out there with different qualifications, different jobs, who could do a fabulous job in this' (Participant Two).

'I wouldn't say it was essential, but it would help to know how the NHS management structure…knowing the process of when somebody comes into A&E, what happens, who's involved' (Participant Six).

'I think it's probably better that she doesn't have a medical background nursing background actually, because she's not here for that. She's here for the social impact of why they are attending…It needs to be someone who really understands the reason why they're here' (Participant Nine).

Barriers were discussed surrounding access to some community referrals. Although an extremely valued and vital programme that '*works hand in hand with the ED Navigator'* (Participant One), Champions has a *'huge'* waiting list due to demand which makes referrals difficult. Similar issues were discussed in reference to CAMHS in terms of the waiting list, but also the criteria for referrals. Specifically for patients with ADHD and/or autism, difficulties were identified with finding services and peer support for families in Lancashire.

The VRN itself was appreciated by the ED Navigator in helping administer the programme. They valued the ability to contact the VRN and enquire about available services they may know of, if for examples they were struggling to find an appropriate service for referral, or if a service has a long waiting list and an alternative was needed. when struggling to find an appropriate service for referral, or if there were long waiting lists. The Champions service [1]was also discussed positively:

'*They look at healthy relationships and look at mentoring. They look at supporting education, housing'* (Participant One)

[1] The Champions programme is also funded by the LVRN. The programme works to support young people aged 10-25 years old who have experience of, or are at risk of, exhibiting offending behaviours. The programme is facilitated by nine football club community organisations across Lancashire.

Maintenance

This section covers how the programme has become institutionalised and what the long-term effects of the programme are/might be. Responses for interview participants focused on organisational impacts, and how the work of the ED Navigator and the ED Navigator programme was further embedded in the hospital. They also commented on longer term impact in terms of information sharing with different agencies and highlighting patient trends.

Organisational impacts

Linked with ideas on effectiveness, at the time of interview the ED Navigator was waiting for 'train the trainer' training to become a champion in trauma-informed practice. This would then allow the newly appointed Health Trainer to deliver trauma-informed training across the trust.

The difference in language used was also mentioned by participants; this change was seen to help staff better source the cause of an incident. Participants felt that there was no longer a culture of victim-blaming, the voice of the child was more focalised, and stereotypes surrounding certain health issues were combatted. Trauma informed practice was agreed to already exist in the trust, but the ED Navigator programme was believed to have helped to increase this:

> *'using self-harm as an example, the NHS have got this labelling of (it) being attention seeking... but it's now looking at why that's happened, how can we support you?'* (Participant One).

> *'Trauma informed has come a lot more to the forefront in safeguarding…That has come around from the ED Navigator, you know, look for the cause of the cause…Staff attitudes are changing in the fact that they're not just labelled as drug dealers, they're not just labelled as alcoholics'* (Participant Six).

> *'I think it promotes a more positive culture, and I think people automatically now go to the Navigator'* (Participant Eight).

Specifically speaking on adverse childhood experiences (ACEs), one participant commented:

> *'We're used to seeing people take overdoses, we'll get them seen by mental health and off they go… But we've never really sort of dug because we only have that small window with them... The ED Navigator has brought a whole new sort of 'We need to look at the impact of ACEs' and no victim blaming culture'* (Participant Nine)

Again on an organisational level, wider impacts to the NHS were mentioned. It was felt that the ED Navigators programme could be economically beneficial in the long term as a result of minimising admissions/readmission related to violence:

> *'it has an impact on the service use of the NHS. It would sort of save money if we weren't admitting patients as a result of violent crime'* (Participant Five).

Information sharing

The work of the programme can highlight specific trends and hotspots to then be shared with external agencies such as schools and the police. An example was shared where a patient sent to ED by his school spoke to the ED Navigator, and felt comfortable disclosing the age of his drug dealer as 14. The Navigator explained the importance of sharing this information with the police, and his vape tested positive for spice. Since linking this case with the school and the police, other schools have come forward, confirming the importance of the programme in sharing intel.

There is also the added benefit in highlighting trends surrounding patient admissions and violence more generally[2]. This aids in combatting stereotypes of violence and violent crime, for example violent behaviour most commonly being seen during evenings and weekends. Mentioned by the ED Navigator and demonstrated in the monitoring framework, the most frequent days for attendances recorded by the ED Navigators were Wednesdays and Thursdays at 20% (n=29) each. Sunday attendances stood at 9% (n=13) and Saturday attendances at 8% (n=11). There are wider connotations of the programme then in informing patterns of youth violence in Preston. However, it is important to note that this figure only represents those attendances contacted by the ED Navigator, and therefore may not be a definite figure of the most common attendance days for violence-related attendances during the week.

Longer-term patient effects

Of those individuals that engaged with the service, only 10% of these (n=10) re-attended in the same quarter. Of these re-attendances, 50% (n=5) were a related attendance to the original patient attendance. Of those individuals not engaged with the service, again only 10% of these (n=2) re-attended in the same quarter.

Future considerations

As reflected in the implementation section, participants felt that the demand for the service warranted more ED Navigators in post. Having two or even three full-time ED Navigators was theorised as a solution to increasing demand on the service. It was also suggested by one participant that the service should be available outside of the current Monday to Friday shift pattern:

> *'I know there'll be a lot that we're missing'* (Participant Two).
>
> *'I think that there is a demand that there's more than one person within that role and it's a seven day service'* (Participant Five).

[2] This evaluation also refers to TIIG data at the end of the report. Although both the monitoring framework and TIIG data analyse attendance, these do not always correlate. The cause of this is being investigated.

East Lancashire Hospital Trust (ELHT)

Reach

This section covers findings in relation to how participants defined who the ED Navigators programme is designed for, and who participates in the ED Navigators programme. Questioning was broad, to allow participants to share their own understandings of the aim of the ED Navigators programme and therefore patients that access the service. Responses by participants referenced the age of the patient and the violence/violent injury they were presenting:

> *'patients that have experienced a violence related injury, or have come into the hospital due to violence'* (Participant Ten).

> *'it's about supporting children from ages 10 to 25, and it's about getting them away, reducing violence in that age'* (Participant Fifteen).

KPIs (shared from the Home Office/VRN) were mentioned in terms of reducing knife-related attendances, reducing serious youth violence tendencies under the age of 25, and reducing non-domestic homicides which involve knife crime.

Specific examples of violence and violent related injuries were also mentioned in terms of reach by some participants, for example patients experiencing exploitation or involved in county lines:

> *'support victims of youth violence between the ages of 10 to 25. So that's anything from knife crime…anything that involved serious youth violence or signs of exploitations, anything that is suspicious'* (Participant Eleven).

> *'it's up to 25 years old and it's for anybody who suffers from serious youth violence, particularly knife crime…provide signposting support to make sure that people aren't just discharged from hospital to nowhere with no support at all'* (Participant Twelve).

> *'looking at if anyone's coming in with an assault, a kind of knife injury and kind of looking a bit deeper ensuring that information sharing is there and most importantly the support in that young person as well'* (Participant Thirteen).

Again, although the target age group of 10 to 25 was identified, there was seen to be some flexibility in patients above this age. This was to the discretion of the ED Navigators, but was dependent on the severity of the injury, i.e. a serious incidence of violence in a patient over 25 would be considered:

> *'(the aim of the programme is) to reduce hospital admissions and for assaults under the age of 25, mainly under the age of 25. If there is a 26 year old who comes in and it's a victim of knife crime, we're not going to turn them away'* (Participant Eleven).

It was found to be important to limit the scope of reach to provide a better service, i.e. quality of care as opposed to quantity of patients. Looking at different models of the ED Navigator programme was seen to 'muddy the water' slightly as their patient focus may differ from that of ELHT:

> *'the hardest bit…trying to narrow it down to those patients who need the most support because you really just want to help everybody, and you can't'* (Participant Twelve).

Other considerations of reach understood the general idea and purpose of the programme:

> '*I'm not sure my thoughts was it was around youth violence, serious youth violence, and getting those people that are either just going into youth violence or on the edge of becoming involved in youth violence and putting them back on the right track…and to capture them at that reachable, teachable moment'* (Participant Fourteen).

This same participant did however overall express confusion about the role and remit of the programme. This was primarily caused by the change in management of the ED Navigators, who were previously managed by Blackpool whilst working in East Lancs but are now managed (and working) in East Lancs. It was felt then perhaps the Navigators were working from a model that needed to be adapted in some areas:

> '*Why are you not linking in with the exploitation nurses? Why are you not doing joint visits with the exploitation nurses…What do the Navigators do? And I think that has been a little bit of some issues that we've never really been clear on so far'* (Participant Fourteen).

Reach defined from the monitoring framework similarly reflected sentiments shared by participants. From January 2024 to June 2024, a total of 194 attendees were included in the data, i.e. contacted by the ED Navigators. It was difficult to discern the reason for initial programme engagement as 78% (n=151) of individuals had missing data for this variable. Of the 194, a total of 28% (n=54) engaged with the ED Navigator programme. Primary reasons for disengagement were identified as being unable to contact the patient, the patient declining support, and the individual having existing agency involvement and therefore Navigator input was not required.

In terms of attendee characteristics, 79% of all attendees (engaged and non-engaged) were male (n=153) and 21% were female (n=41). The age of patients matched ideas of scope identified in the interviews. The 15 to 19 age group equated for the majority of individuals at 37% (n=71), followed by the 20 to 24 age group at 25% (n=49). Only 2% of patients (n=4) fell in the 30+ category; all of these patients were 30 years of age. The youngest patient included in the framework data was 10, and the oldest was 30.

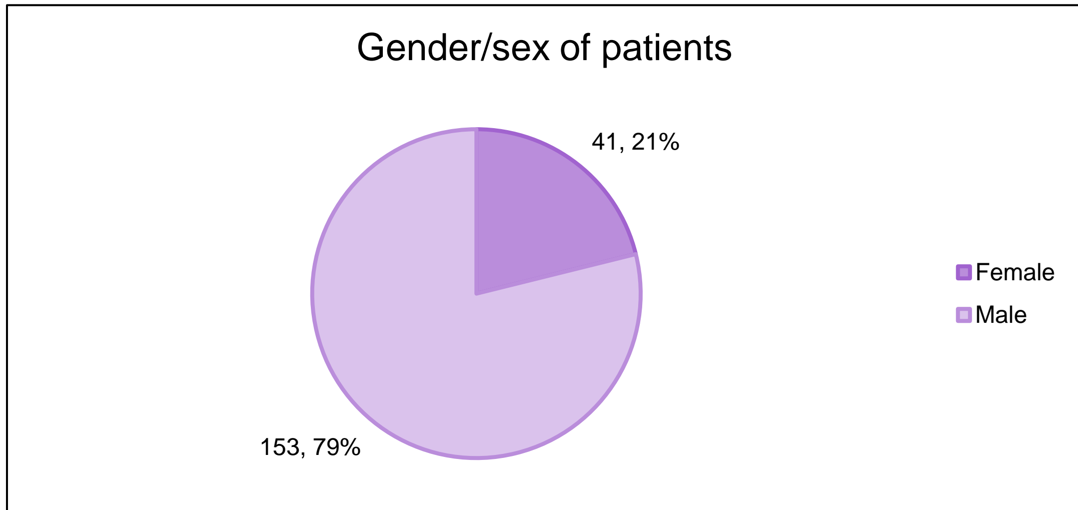

Figure Eight – Gender/sex of patients

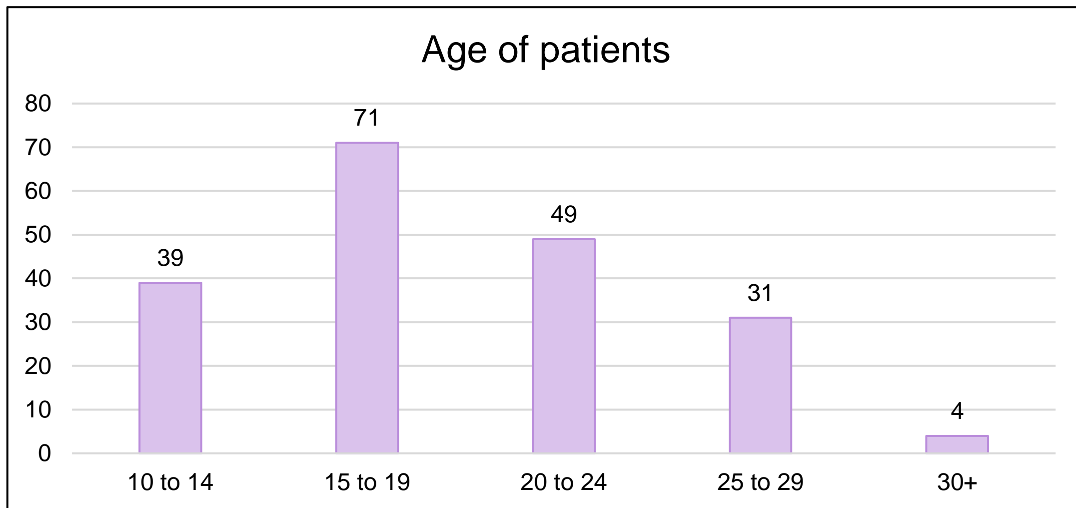

Figure Nine – Age of patients

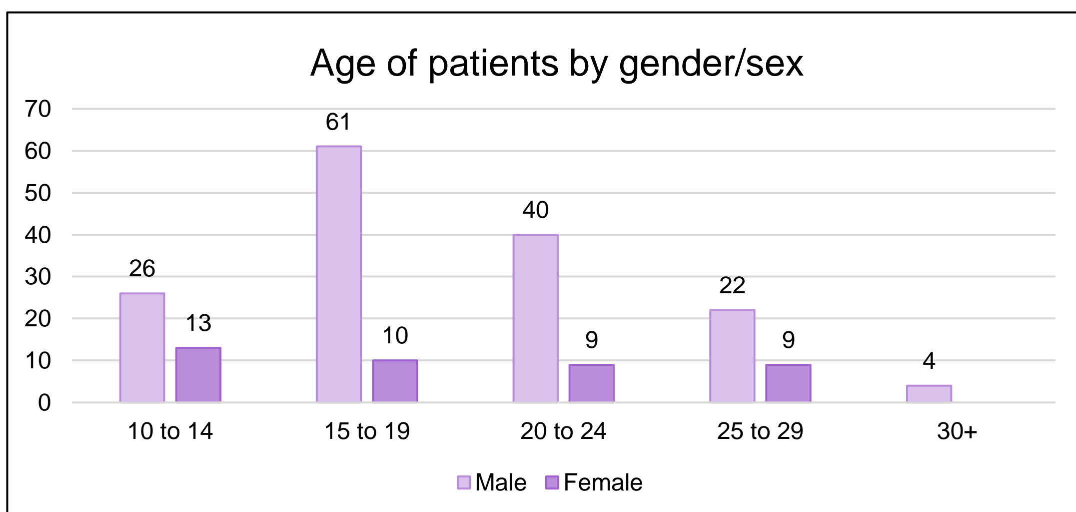

Figure Ten – Age of patients by gender/sex

Effectiveness

This section discusses findings in relation to the benefits of the ED Navigators programme, and the extent to which the programme is seen as likely to achieve its purpose. Again, questioning followed the participants ideas of what benefits the programme achieves. Aside from benefits directly related to patients, participants indicated great benefits to staff and the added benefit of the approach adopted by the programme.

Patient benefits

ED Navigators can provide targeted support dependent on patient needs. This includes supporting them in ED, for example making them a cup of tea, making sure they are comfortable, and liaising with medical staff. The programme was seen to be a broad service that tailors support to the needs of the patient providing a holistic outlook on care, for example:

> *'trying to steer them away from that lifestyle because a lot of our young people are quite entrenched in maybe gangs or you know drug dealing, anything like that, and it's supporting them to know that there's a different route and it's to give them aspirations in life to make them think 'You know, I've actually got something to work towards'* (Participant Eleven).

Linked to the benefits of a healthcare environment (see below), respondents recognised that ED Navigator patients may feel both safer and more comfortable accessing and receiving care:

> *'I think at that moment in time when they're coming into hospital, sometimes that can be crisis, that can be a crisis point for them'* (Participant Ten).

> *'we're in a confidential space where we've got security and where we can say no visitors and we can, we can keep somebody safer than in a normal place'* (Participant Twelve).

The collaborative approach of the ED Navigator programme, working with different stakeholders dependent on patient needs, was seen to be a benefit to patients. This meant that patients with multiple concerns could receive targeted care that covered more than one issue:

> *'for me, the outcome is that we've met the health needs hugely, not just with ED Navigators but as a multiagency alongside social workers, family support workers, school nurses…it can't be done alone in isolation'* (Participant Thirteen).

Of those engaged with the ED Navigator programme (n=54), 76% of these individuals (n=41) were referred elsewhere. . There were also 41 referrals made for non-engaged patients . A total of 95 patients therefore were given a referral.

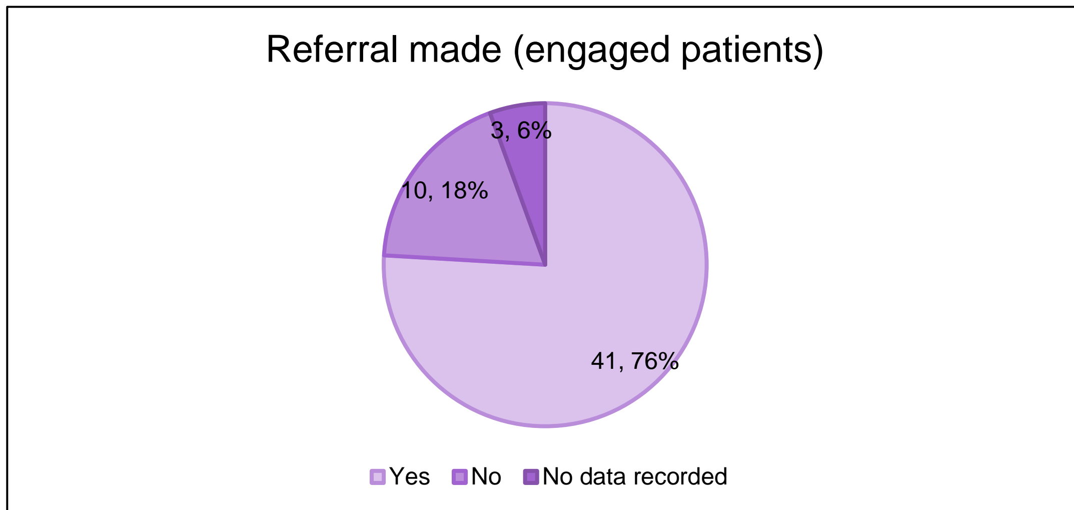

Figure Eleven – Referral made (engaged patients)

Referrals for engaged patients were most commonly made for mental health (n=15) followed by violence (n=11).Within the other category, reasons given included referrals related to housing, anger management, and bullying in education. Examples of referral services included NEST (n=10), LVS (Lancashire Victims Service) (n=6), and Champions (n=2). Of those referrals made, an attendance rate of 33% (n=18) was documented. It is again important to note here however that 48% of referrals made did not have information of whether or not the referral was taken up by the individual.

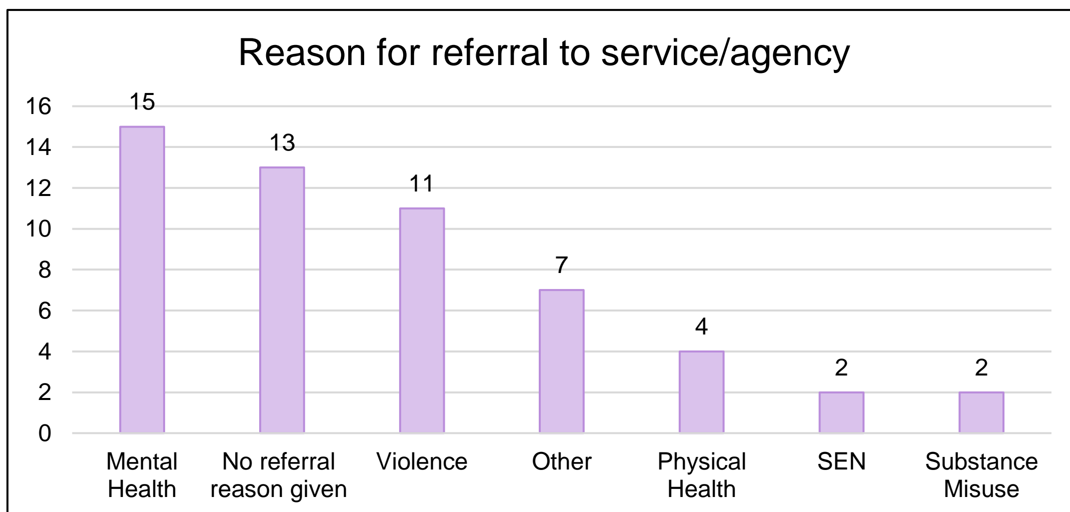

Figure Twelve – Reason for referral to service/agency (engaged patients)

More generally, the monitoring framework captured 54% (n=29) of engaged individuals having an improved outcome due to the work of the programme; the most common improved outcome was mental health (n=10).

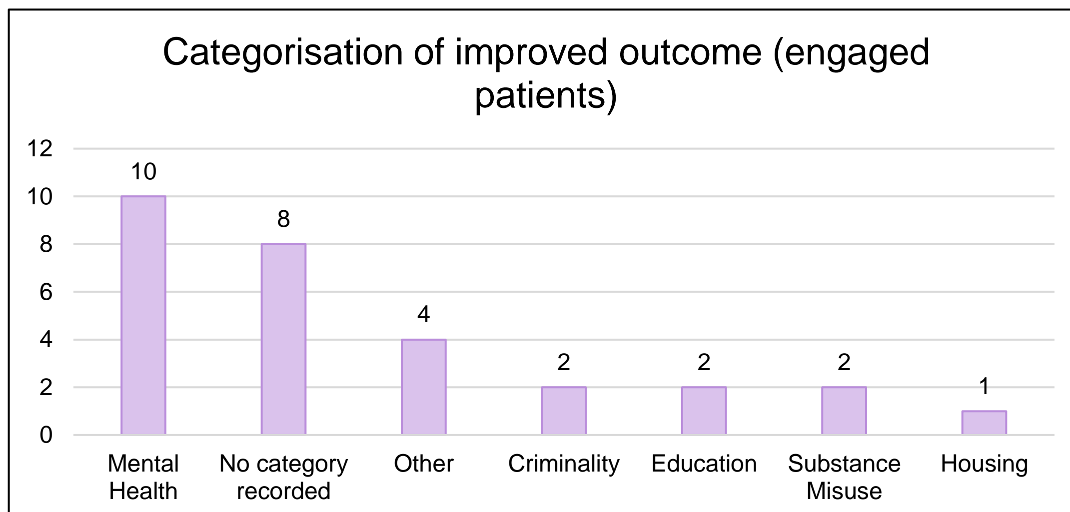

Figure Thirteen – Categorisation of improve outcome (engaged patients)

Specific details of outcomes were wide ranging dependent on the needs of the individual, and often included an indication of multiple referrals being made and/or avenues of support:

> *'Support provided with return to school following incident. Referral to NEST victim support. Support provided with liaising with the police'.*

> *'Refer to anger management, CSC, police, advice given regarding referral for ADHD assessment'.*

Reference was also made to the autonomy given to patients in engaging in the service. It was recognised that patients could not be forced to participate, but that later down the line, the programme and work of the Navigators still fostered the ability to access support:

> *'But if you know there's contact details and someone who can help, sometimes they might look back on it and think 'Oh, actually they might really help me' and it might take a bit of time'* (Participant Thirteen).

This was also recorded in the monitoring framework data:

> *'Declined all support offered but explained how to contact us again if further support needed in the future'.*

> *'Declined support. Details provided for LVS should he wish to self-refer'.*

Staff benefits

Participants generally valued the insight of the ED Navigators, and found an added benefit of the programme to be the following-up with patients. This then allows for a prolonged element of care and knowing that the package of support delivered is sufficient, but also for feedback on a particular case or patient. This was seen to be

of particular relevance to ED staff who are often pressured and do not have the capacity to adopt a holistic approach:

> *'not just patching people up in A&E and then sending them home, there's somebody there that's following them through, following them up in the community and making sure they're OK afterwards' (*Participant Ten).

> *'you need feedback. So because for me, if I've got that person, I'm still carrying that risk for that person until somebody else says 'I've got the risk''* (Participant Twelve).

Collaboration amongst staff was valued, where the ED Navigators could share experience and vice versa on different ways to approach a situation and examples of best practice. As the safeguarding team is office-based, there is then a level of information sharing and shared support amongst staff surrounding community trends. The ED Navigators were therefore able to go out and see young people in the community and share contacts with staff members, which 'improves services and improves our roles' (Participant Fifteen).

Benefit of health-care setting

Participants referenced the added benefit of having healthcare involvement and a healthcare setting for the ED Navigator programme. This included benefits such as being able to refer into specialised services, being able to support patients through their patient journeys, and being able to explain complex concepts:

> *'(The ED Navigator) can refer into certain services that probably wouldn't accept referrals from outside or somebody that's not clinical. So for instance, the specialist dental service only accept referrals from professionals'* (Participant Ten).

In terms of environment, it was felt that having the programme based in a hospital could allow for wider, health based issues surrounding a patient's admission to be addressed:

> *'I'd say having a health input is essential really because a lot of young people who are victims of serious violence also have health problems, so they either could have mental health problems'* (Participant Eleven).

> '*we've got access to people that have come in, you know, a lot of violence they don't necessarily access all the services, but they have come into health quite often…I think a lot of people will be missed if it wasn't in a healthcare setting'* (Participant Twelve).

> *'You know there are exploitation concerns and they have come in with injuries but also across from that they've got all the health needs as well. So they've come in with one thing, but the health needs are much wider'* (Participant Thirteen).

Familiarity of a healthcare setting and support from a healthcare professional also allows patients to feel more comfortable in disclosing sensitive information, for

example details on an injury or the perpetrator. This information can then be shared with criminal justice agencies where otherwise it would not be known:

> *'With a healthcare professional, I think they feel a bit more relaxed to be able to say what they want to say. Whereas police, it's a little bit scary because they don't know the process'* (Participant Ten).

Adoption

This section discusses responses on the adoption of the ED Navigator programme. This includes how staff responded to the adoption of the programme, important factors in facilitating successful adoptions, and any barriers therefore faced in adopting the programme.

Raising awareness

When thinking about programme adoption, awareness was frequently mentioned. Both formal and informal methods were discussed, from informal conversations about the programme with staff to attending doctor intake to ensure new doctors know about the programme. Awareness raising then is a continuous process in some parts. Going into ED and talking face-to-face one-on-one about the programme was seen to be the best method:

> *'making staff aware of this service is essential. If you don't do that, it's not going to work, is it?'* (Participant Fifteen).

A barrier adoption was that the ED Navigators were already known to hospital staff, causing some initial confusion around what their new role actually was. Misunderstandings initially however were combatted by ensuring visibility in ED, raising awareness of the role and talking to people about the programme:

> *'I think it's been well received because we've got those eyes going into the department'* (Participant Thirteen).

However, it was felt by participants that it was not always easy to have conversations about the programme due to the believed huge demand on the service and the cycles of staff coming through ED. The ED Navigators therefore have to educate each rotation of new doctors about the programme, how it works, and what their role is.

Trial and error

Trial and error was also mentioned when setting up the service, and the ability to adapt the programme if something was not working effectively:

> *'I think sort of trial and error quite a lot in what works and what doesn't to build up the service is really, really important'* (Participant Twelve).

Linked here to implementation, a change in shift patterns was given as an example by the ED Navigators to ensure that their working patterns matched external service opening times. However, one participant questioned whether this adaptation had

been made with the programme in mind, or if the adaptation was instead made to the benefit of the ED Navigators themselves.

Relationships with staff

There was also a barrier acknowledged in the structure and management of the ED Navigators themselves. They are currently employed and managed by ELHT, but have previously been employed by Blackpool whilst working in ELHT. This was seen to cause some confusion, and caused difficulties in the ED Navigator fully intergrating into the trust and working with staff.

Difficulties with hirings and therefore reduced capacity of other staff at East Lancs was also mentioned as a barrier to adoption:

> *'I haven't been able to be as close to the ED Navigators as I would have liked…I just haven't had the time'* (Participant Fourteen).

The same participant questioned what the role of the ED Navigator was, their overall remit and responsibilities, and how they best 'fit'. Their comprehension of how the service should be adopted and therefore ran reflected the nurse-led model, where they felt health-based issues were the intended focus. There seemed then to be some difficulty in distinguishing a clinical nursing based role to the *specific* role of the ED Navigator:

> *'it isn't very clear on their role is to manage health issues. Is it just that or is it, you know, because taking kids to boxing lessons, you don't need a nurse to do that. That could be a youth worker or anybody…the remit of why it had to be an ED nurse by background initially was because they would be able to identify the health concerns and support with those, but the remit has massively changed beyond health'* (Participant Fourteen).

A specific ongoing example was shared with issues around missing safeguarding. When screening patients and safeguarding does not exist, this is picked up either by the ED Navigators themselves, or passed onto the safeguarding team:

> '*The safeguarding in all A&E departments at the minute isn't, you know, it's not top notch is it at the minute, and it's literally due to you know capacity and time'* (Participant Eleven).

The ability here to 'safety net' was seen with mixed responses by participants:

> *'it does cause a bit of friction in the team because it's like 'Well you notice it you've picked it up so why're you not dealing with it. Why are you passing it over to us to deal with'. And then there's also friction with ED because they'll pass it back to ED to say 'You've missed this"* (Participant Fourteen).

> *'They do pick up cases and maybe missed safeguarding cases which aren't linked to violence…but that can't be a negative thing because they're safeguarding children…it's actually really beneficial'* (Participant Fifteen).

Implementation

This section discusses responses focused around programme delivery. Emergent themes include how the programme is delivered, what is important in delivering the programme, and barriers that are faced. Overall, participants were not aware of any changes made to the programme since adoption and during implementation, some feeling that they weren't involved enough to comment if changes did exist. However, the ED Navigators did both reference the ED Navigator forum created by the Navigator from RPH.

Method of delivery: nurse-led model

The model at ELHT is nurse-led and utilises patient screening as opposed to a referral based system. Every attendance in the last 24 hours through A&E is screened to see if they fit the criteria for the ED Navigators programme. Staff did also have the option to refer patients, but this was an infrequent occurrence. Screening was seen by some to be a benefit, allowing the ED Navigators to assess all potential patients for the programme:

> '*we don't have a referral pathway to the ED Navigator service. We screen our patients because we don't want anyone to slip through the net. We know EDs are horrifically busy at the minute, and asking a doctor to do a referral…It could get missed and it could be a serious incident that's been missed'* (Participant Eleven).

However, one participant questioned if the screening model was the most effective method of accessing patients:

> *'looking through trolls and trolls of attendances to pick out things takes up so much time…But then it is difficult in an ED department, it is so busy people don't want you, you feel like they're in the way'* (Participant Fourteen)

They also questioned the necessity for a clinical background for the ED Navigators, suggesting whether a different background would be better placed. The experience of the person, for example of engaging with young people, was seen as more important than a nursing qualification. This was also suggested in part as a way to limit costs by having a lower banded employee in the role:

> *'My view is that you could run the programme with support workers…You know if it's that the young person has to come back to fracture clinic in two weeks' time, the youth worker just needs to know they need to come back in two weeks' time for this appointment…Why does that need to be a nurse, you know?'* (Participant Fourteen).

This participant questioned this reasoning and the role of the ED Navigators in looking at the mechanisms of a patient injury:

> *'But all these young people will be seen by a nurse and a doctor. We will be expecting (them) to pick that up and question that. So why do you need then somebody else to come in?'* (Participant Fourteen).

Other participants appreciated the clinical nursing background of the ED Navigators and how this was integrated into the programme. They felt then ED Navigators could use their professional curiosity to understand the mechanisms of an injury and question where description of injury cause did not match the injury presented. It was also felt that there was added knowledge in terms of healthcare referrals and public health knowledge, for example advising on alcohol and drug cessation.

> '*I think it is important to have somebody in an ED Navigator team that has clinical experience…you can look at the mechanisms of how something's happened. You can look at the state of somebody's injuries. You know, you can get that extra support. You can speak to the doctors'* (Participant Twelve).

> *'from a health safety perspective, I think it's great we've got a nurse doing it'* (Participant Thirteen).

> *'having that health knowledge is obviously essential to do that role because you're understanding the health side of it, and then link (it) in with everything else'* (Participant Fifteen).

The ED Navigators themselves acknowledged their clinical background and the support they were able to provide first-hand. For any health-based matters they could use their knowledge and address the concern from a health perspective. For other issues for example mental health concerns, they made appropriate referrals:

Working with patients

Participants recognised that there needed to be a nuanced approach to the service for each patient:

> *'Everybody's different and the way you speak to people, it could be different for one person than another'* (Participant Ten).

> *'really good at tailoring individual support to individuals…There's definitely no one-size-fits-all approach in safeguarding, in any safeguarding, so it's more important than anything else that we look at each individual as an individual'* (Participant Twelve)

It was also regarded as a service that can help those young people that may otherwise not receive support via other services:

> '*It's a great support for these young people… sometimes these young people have slipped through the crack and they've got no support whatsoever. I'd like to think that we're offering that support and we're capturing these young people at a time when they need it most. Because it might not be that anybody at school takes notice of something that's going on or anybody at the GP surgery'* (Participant Ten)

For those that do engage, the need for a more formalised method was identified. At the time of interview, a QR was in the process of being designed to receive feedback from patients and to hear how they felt about the support given by the ED Navigator. Questions include if improvement have been made for the patient, if they reported the incident to the police and if not why, and what could have been done better in the future. This was felt to be easier for both the patient and the Navigator in collecting feedback.

Demand

Demand for the programme is huge, with the with the number of patients meeting the programme criteria being 'absolutely staggering'. Demand on the service was also thought to be increasing. It was important then to manage expectations around the service. Linked here to ideas previously discussed around reach, patients with more serious violent-related injuries like a stabbing are prioritised in programme inclusion:

> *'There's no point in picking 10 patients if you can only give them an hour each, you know you're better off picking up the more serious two and giving them as much time as you can because you know, they're the ones that I'm not saying the other ones don't need as much as much support. But you know, we can't fix the world'* (Participant Eleven).

Working with community services and external agencies

The importance of forming relationships with community services/agencies was stressed as an important element of the programme:

> *'you've got to make links into the community, you've got to be able to connect with stakeholders from every area for your service. You've got to build that trust'* (Participant Twelve).

The ED Navigators worked with a wide range of community agencies and services. These included but were not limited to criminal justice agencies, schools, mental health services, the probation service, and alcohol and drug services. Again, multi-agency working was vital and a combination of referrals for patients ensured a positive impact: 'mum said it was life changing. It has literally changed his life'.

Participants did recognise a barrier in accessing community service and creating relationships. Accessibility was acknowledged as a barrier here, both for the ED Navigator and for patients looking for service without Navigator guidance:

> *'It would be very difficult for, say, a 15 year old on a mobile phone to try and find all the support links that they might need.. things like websites not being updated, people's funding being pulled'* (Participant Ten).

Pulling together knowledge on what services are available, what is their current capacity, and if they have a waiting list or not was difficult for the ED Navigators. To alleviate this, the ED Navigators have an index of community services that they refer to when looking to make a referral.

Linked here with adoption, participants had differing opinions on the capacity of the ED Navigators to determine what community services were available for referral.

Some participants felt that the Navigators conducted a good level of research into available services, whereas others questioned if there was capacity in their role to do so.

The ED Navigators themselves shared difficulties in accessing these services. Finding agencies who have funding was difficult, as well as certain services having long waiting lists. However, going out in the community meant that the ED Navigators could gain knowledge first-hand from those in the community, for example school nurses, the local community centre, or other services themselves.

Support within the role

Having two staff in post meant that first and foremost, the ED Navigators could support one another and 'bounce off each other'. Discussions were frequently had around specific cases, service effectiveness, any service changes that might need to be made. Monthly one-to-one meetings were also had with their manager, as well as support and information sharing with the safeguarding team:

> *'There's management structure in place for you to be able to go and say 'This is happening' or 'I'm not coping' or 'I'm worried about this person' you know, so you're not actually taking it home with you'* (Participant Twelve).

As well as this, both ED Navigators referred to the ED Navigators forum, where they had the opportunity to share cases and best practice with other ED Navigators.

Maintenance

This section covers how the programme has become institutionalised and what the long-term effects of the programme are/might be. Responses for interview participants focused on organisational impacts, and how the work of the ED Navigator and the ED Navigator programme was further embedded in the hospital. They also commented on longer term impact in terms of information sharing with different agencies and highlighting patient trends.

Organisational impacts

The work of the programme helped to further integrate trauma-informed practice into the hospital. Shared knowledge on particular issues surrounding violence meant that staff members could then be better informed on what is being seen by ED Navigators, and how that may then relate to their own patients:

> *'I think the trust are more trauma aware and that's one good thing... the staff are a bit more aware of the things that they weren't before, such as county line'* (Participant Ten)

The trauma-informed approach was also institutionalised amongst A&E staff by the ED Navigators, particularly during new doctor intake. The ED Navigators conduct junior doctor teaching where they discuss trauma informed-practice, serious violence, and recording the voice of the child/patient. As highlighted early when discussing adoption of the programme, this was seen as an important duty in raising awareness of the service. As such, with this increased knowledge, staff could consider ways of working that prevent re-traumatisation of patients. A specific

example was given that a female patient with a history of sexual violence may feel more comfortable with a female practitioner.

Information sharing

Participants identified that the programme could provide impactful knowledge to external agencies, that would then benefit the local area and have a long-term effect. The programme was thought to be '*like a missing puzzle piece that goes together so we can all address violence in the community'* (Participant Ten). Examples were shared that pertained specifically to the police and to schools. These included using framework data to identify 'hotspot' areas for assaults so that extra police patrols could be placed, and schools in areas where children were using THC vapes could be visited by drug and alcohol workers:

> *'it's sharing the data and ensuring that it can be used in partnership to tackle serious violence in the community, not just from a health perspective, but from a police and education (perspective)'* (Participant Eleven).

Longer-term patient effects

Of those individuals that engaged with the service, 31% of these (n=17) re-attended in the same quarter. Of these re-attendances, 53% (n=9) were a related attendance to the original patient attendance. However, of those individuals not engaged with the service, only 20% of these (n=28) re-attended in the same quarter.

Future considerations

As reflected in the implementation section, participants felt that the demand for the service warranted more ED Navigators in post. Having two full-time ED Navigators was theorised as a solution to increasing demand on the service, but also a way of the Navigators not having to worry as much about missing patients/information:

> *'So yeah, a bigger team would be nice'* (Participant Eleven).

> *'I think there's way too much work for one, and I think there's probably enough work for two, but we've got 1.5'* (Participant Twelve).

For any continuation of the programme, one participant felt that there needed to be further consideration into the programme in terms of what the role and the programme are trying to achieve. They felt that they had not seen a great impact of the programme, and as a result found it something that was difficult to champion:

> *'But if it's going to continue, I think yeah, just needs a shake-up. You know, perhaps a reset button'* (Participant Fourteen).

Summary

Using the RE-AIM framework, this mixed-methods evaluation has explored how RPH and ELHT have implemented the ED Navigators programme, including facilitators and barriers to the programme. An overall summary for each trust can be seen below, as well as a comparison table of the two trusts highlighting key similarities and differences.

Royal Preston Hospital

	RPH
Reach	Participants defined reach in terms of patient age and youth violence, e.g. a violent injury or a violent crime. Focal ages were described as 10 to 25 with flexibility for patients in their early 30s dependent on Navigator discretion and capacity. Data from the monitoring framework however indicated 16% (n=23) of individuals were over 30, with the oldest patient being 46.
Effectiveness	Participants discussed a wide range of benefits of the programme pertaining to patients, patient families and staff members. These included patients having their voices heard, families feeling supported (some for the first time), and staff having higher levels of morale. For patients specifically, 67% of engaged individuals had an improved outcome due to the work of the programme. The benefits of both the trauma-informed approach and the healthcare setting were also shared. The trauma-informed approach allowed the ED Navigator to look at the whole picture of a patient's care, and the healthcare setting fostered a trusting, safe environment for patients.
Adoption	Participants placed importance on raising awareness around the programme and communicating this to staff. Some participants felt more could have been done in this area. Staff relationships were also cited as an important factor in adoption. An acknowledged barrier was determining the initial 'fit' of the role within the existing safeguarding team. Both the visibility of the Navigator and the collaboration with other staff members allowed for an overall smooth adoption of the programme.
Implementation	Participants valued the ability of the programme to take an individualistic approach to patient care. Relationships with community agencies and external services were seen as vital in delivery, and an important part of the Navigator role. However, managing expectations of the scope of the programme was stressed. Demand on the service is

	extremely high, and at times there are difficulties in accessing certain referrals due to long waiting lists.
Maintenance	The programme has helped to better institutionalise trauma-informed working into the hospital. This included demystifying patient stereotypes, improved language use for patient care, and reduced victim blaming. Information sharing with external agencies such as the police, as well as the long-term monitoring of trends was also identified. Only 10% of patients engaged in the programme re-attended in the same quarter. However, this same figure was seen for those that did not engage with the programme.

East Lancashire Hospital Trust

	ELHT
Reach	Participants defined reach in terms of patient age and youth violence. Specific reference was made to KPIs and issues pertaining to violence, e.g. county lines, exploitation. Focal ages were described as 10 to 25 with flexibility for patients in their late 20s. This was dependent on the discretion of the Navigator and severity of the injury presented. Monitoring framework data identified the same scope in reach, with no individuals over 30 included in the data. There was some confusion identified around reach and what the role of the Navigator/the programme was, and what it was ultimately trying to achieve.
Effectiveness	Participants discussed benefits pertaining to patients and staff. This included providing tailored care and a safe space for patients, and sharing best practice amongst staff. For patients specifically, 54% of engaged individuals had an improved outcome due to the work of the programme.

	The benefits of the healthcare setting were again shared. It was felt the environment allows for wider, health based issues surrounding a patient's admission to be addressed, as well as the ability to refer into specialist medical services.
Adoption	The ability of 'trial and error' was expressed, making any necessary changes to the service to improve efficacy. Raising awareness was identified as an important facet of adoption, however conversations around this can be difficult due to the busy nature of ED. Barriers relating to adoption included the ED Navigator already being known in the hospital from their previous role, and again how the role best fit into existing systems.
Implementation	Delivery of the programme was discussed with reference to the screening and nursing-led model. Responses on whether or not this model was effective were mixed, but overall positive. Some respondents valued the clinical experience of the Navigators in their ability to add knowledge in terms of health care healthcare referrals and public health knowledge. There was an indication that other experiences, for example engaging with young people, were more warranted of the role than a nursing qualification. The screening led approach meant that patients could be safety netted, however it was queried as being time consuming and ineffective. Delivery was also theorised in terms of working with patients and working with community organisation/external agencies. Demand on the service was seen to be high and it was felt overall that the Navigators may not have enough capacity in their role to source agencies to refer on to.
Maintenance	The programme has helped to better institutionalise trauma-informed working into the hospital. This included sharing learning on specific topics such as county lines, and teaching new junior doctors. Information sharing with external agencies such as police but also schools, as well as the long-term monitoring of trends was also identified. 31% of individuals engaged in the programme re-attended in the same quarter (within three months). However, only 21% of individuals who did not engage in the programme then re-attended in the same quarter (within three months).

Comparison of trusts

	Comparison of RPH and ELHT
Reach	Definitions of reach for both trusts include a reference to violence/violent injury, and a reference to age. Both trusts demonstrated some flexibility in the upper age limit to include patients over the age of 25, capped at either late 20s (ELHT) or early 30s (RPH). In the monitoring framework data, the ED Navigators from ELHT only contacted patients within this defined age range, however some individuals in the framework data for RPH were in their late 30s and early 40s.
Effectiveness	Both trusts identified similar programme benefits to both patients and staff members. The ability to highlight the voice of the child and provide targeted care was seen as important for patients, and the ability to share best practice and knowledge was seen as important for staff. Participants from RPH stressed the important of benefits to patient families, which was not discussed by participants from ELHT. Both trusts also valued the trauma-informed approach of the programme, and the healthcare setting.
Adoption	Raising awareness of the programme and building relationships with staff were identified as important for adoption. Participants from both trusts however felt that more could be done to better raise awareness. ELHT also identified the room needed for 'trial and error' in adapting practice. Both trusts identified finding a 'fit' for the ED Navigator role in existing teams an initial barrier to adoption. This was questioned more in ELHT surrounding the clinical background of the Navigators and how this worked with the role of the ED Navigator.
Implementation	Participants from both trusts discussed delivery in terms of working with patients and working with community agencies and/or external organisations. Difficulties in making referrals to community agencies were discussed by both trusts in terms of long waiting lists. The method of programme delivery was referenced by participants from both trusts, however greater reference was made here by participants from ELHT. This focused on both the nurse led aspect of the programme, and the screening process. Both trusts did discuss the background of an ED Navigator and whether there was a need for a clinical background.

	Responses within both trusts were mixed on this topic. Overall, participants from RPH did not feel a clinical background was a role necessity, whereas this was viewed with more importance amongst participants from ELHT. These viewpoints correspond to the background of the current Navigators in post in each trust respectively.
Maintenance	Participants from both trusts identified how the programme has institutionalised trauma-informed working and practice into the hospital. They also commented on information sharing with schools and police about long-term trends. For future iterations of the programme, both trusts identified the need for more ED Navigators in post due to the demand on the programme. One participant at ELHT indicated that a future iteration of the programme would involve making delivery changes, an opinion that was not shared by RPH participants.

Additional Information to Support Evaluation

TIIG data

Although not a part of this service evaluation, TIIG data analysis has been important in initial design of the ED Navigators programme. An overview of relevant TIIG data analysis has been referenced below to help contextualise recommendations for future interactions of the ED Navigators programme.

TIIG data (January 2016 – June 2023) for assault attendances to all Lancashire hospitals indicates that males were most commonly aged 20-24 years old and females were aged 25-29 years old. As such, the LVRN ED Navigators model prioritises anyone aged 25 and under, as per the Home Office success measures, however there is flexibility to support older individuals, in line with the data described above. The Home Office returns include data for patients aged 25 and over as well, to account for the work with some people above the age of 25. However, those age groups most frequently contacted by the ED Navigators from both trusts does not correlate with the TIIG data.

Analysis of ED attendances by TIIG across pan-Lancashire sites demonstrates that the days and times with highest demand are Saturdays into Sundays (10pm to 5am). Shift patterns therefore were originally based on times of greatest need as identified by this data, and the service was designed to be outside of the current Monday to Friday shift patterns adopted by RPH and ELHT. Shift patterns have moved away from those identified in the TIIG data. One reason given by the ED Navigators from ELHT for this was the importance of having shift patterns match opening times of referral services/agencies.

ED Navigator programmes in Blackpool Victoria and Lancaster Hospitals

Although not a part of this service evaluation, informal conversations were had with both Blackpool Victoria Hospital and Lancaster Hospital, where the ED Navigator programme is also running in the early stages of implementation. Information on the two programmes has been included here to provide context for any future evaluation work.

Blackpool Victoria Hospital

Blackpool is a seaside town which has a steady flow of violence, but there can be an increase in instances of violence when specific events are on. There are challenges with drug use in the area, especially ketamine amongst the population ED Navigators work with (ages 10-25).

The ED Navigator programme has been present in Blackpool since January 2020 however the current ED Navigator is very new to post. There are usually two full time ED Navigators in post, but one is currently on long term leave and the post has not been filled in their absence. The work pattern of the role includes shifts, which

involve evening and weekend work. The current navigator is currently working to try and establish an overview of patterns of violence to look to direct future work patterns around to support when referrals peak. The Navigator is supported by a line manager who they receive regular supervision from.

The ED Navigator is part of the safeguarding team but uses the ED department as a basis for visibility of themselves and the role. This allows for referrals to be made in person from colleagues (in ED and in outpatients, such as fracture clinics), in addition to other referral pathways (including contacting the ED Navigator on their Trust mobile, completing a referral form or emailing the dedicated mailbox). In addition, the ED Navigator monitors patient lists in ED Navigators and identifies people who are potentially suitable themselves. Beyond the hospital they work closely with Champions and School nurses, for both referrals and signposting to.
In addition to working with partner organisations, the role involves short-term and long-term work with clients. The format of this work is personalised to need, and can involve supporting clients to return to school, undertake new opportunities and undertaking home visits. The two posts are needed to enable this work to be undertaken.

The ED Navigator suggests future programme and evaluation work could look to see how better links with primary care could be made. GPs may be able to identify patients who would benefit from being supported by the ED Navigators. However, this would then also have to look an increase in staff resource to support additional referrals.

Lancaster Hospital

The ED Navigator role in Lancaster is currently a single position full time role, filled by an individual with a background in domestic abuse support and policing. They started the role in 2024, taking over from a previous navigator. However, the post had not been filled for the 10 months prior to the current ED Navigator starting. It was therefore not an established position and had to be introduced like a new service with the commencement of the current post. The role involves working shifts which include evenings and weekends.

Lancaster is a large geographical area with organised crime, including travelling crime (through neighbouring counties), which bring complexities. There are also a lot of vulnerable communities in the area. This includes have a large number of children's care home, and subsequently large numbers of those who have recently left care. The main concerns for the area are criminal exploitation and violence surrounding this.
The role sits within the safeguarding service but works closely with the emergency department, and is now established amongst colleagues working in these areas. The pathway for accessing support from the role includes a combination of referrals and screening by the ED navigator. The role works with patients aged 10-25 (sometimes older patients too), providing either signposting to other service or long-term support. There is data being captured using the same template as other sites. In addition case studies are being captured by the ED Navigator.

Recommendations for future evaluation work include a focus on how this role works with the context of the geography of Lancaster (the border of Lancashire and Cumbria), how the intervention works to support vulnerable patients from the surrounding area and hospitals and experience of the referral system.

Limitations

Due to ethical and time constraints of the evaluation, only the ED Navigators and NHS staff from each trust that work with/refer into the programme were interviewed. To gain greater user insight into the service, it would have been beneficial to interview patients that have/have not engaged with the service.

Due to the current phase of programme development at Blackpool and Lancaster sites it was not possible to undertake the same level of evaluation at these sites.

Recommendations

Following the evaluation, the authors make the following recommendations.

- A consideration of how patient needs are prioritised, and how demand for the service is managed by the ED Navigators.
- An evaluation of how the duties of the ED Navigators (e.g. awareness raising and information sharing about the programme, collating sources of referral services/agencies) are balanced with direct patient contact.
- A consideration of how shift patterns are designed for ED Navigators to ensure that patient needs are met.
- A consideration of the number of ED Navigators assigned per trust. An increase in the number of Navigators could increase the number of patients contacted, diversify shift patterns for evening/weekend working, and/or increase capacity for researching referral services/agencies.
- Following on from the work of the ED Navigators at the time of interview, a development of the feedback process for patients who engage with the ED Navigators programme. This could include data collected prior to and post programme engagement to improve knowledge around patient outcomes, patient experiences, and the need for any improvements to the service.

Bibliography

Home Office (2020) *Violence Reduction Unit Interim Guidance*. London: Home Office.

Lancashire Violence Reduction Network (2020a) *About us*. Available at https://lancsvrn.co.uk/about-us/ (accessed 26/09/2024).

Lancashire Violence Reduction Network (2020b) *What is the ED Navigator scheme?* Available at https://lancsvrn.co.uk/ed-navigators/ (accessed 26/09/2024).

RE-AIM (2024) What is RE-AIM? Available at https://re-aim.org/learn/what-is-re-aim/ (accessed 26/09/2024).