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Evaluation of the Hampshire and Isle of Wight No Limits (ED/SP/111) Navigator Programme

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Evaluation of the Hampshire and Isle of Wight No Limits (ED/SP/111) Navigator Programme

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About this report

Hampshire and the Isle of Wight was one of several areas allocated funding by the UK Government, to establish a Violence Reduction Unit (VRU). To inform the continued development of the Hampshire and Isle of Wight VRU, Liverpool John Moores University (LJMU) has been commissioned to evaluate selected programmes of work that have been funded by the Hampshire and Isle of Wight VRU. This report forms one of a suite of outputs from this evaluation work programme and specifically presents a service evaluation of the Hampshire and Isle of Wight No Limits (ED/SP/111) Navigator programme.

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Executive Summary

Navigator programmes are hospital-based violence prevention programmes that typically involve Youth Workers working in hospital settings (particularly Emergency Departments [EDs]) to support and engage children and young people (CYP) who present at hospital having experienced violence, being at-risk of violence, or presenting with another related vulnerability (e.g., substance use, mental health issues). These programmes are being delivered as part of a broader suite of interventions following a national response to the prevention of youth violence using a public health approach. Navigators work in a person-centred way utilising the 'reachable and teachable moment' to engage CYP, identifying their support needs, and co-creating an action plan that is flexible and tailored to support their specific needs. Navigators build trust and develop a relationship with CYP (and their families), providing support for immediate crisis points, and support in setting short and longer-term goals. Navigators will signpost and refer CYP to support services where appropriate (e.g., for mental health and wellbeing, substance use, and family support), and when necessary, to statutory services for safeguarding.

Hampshire and Isle of Wight Hospital Navigator Programme

Since 2022, five Emergency Departments (EDs) across Hampshire and Isle of Wight (Basingstoke, Isle of Wight, Portsmouth, Southampton and Winchester) have been funded by Hampshire and Isle of Wight VRU to implement a Navigator programme, utilising Youth Workers and Social Prescribers[1]. The implementation of these workers is supported strategically by the Hampshire and Isle of Wight Violence Reduction Unit (VRU), with their implementation part of an approach to meet the joint broader aims of the VRU, including reduction in vulnerabilities and vulnerable people, reduction in repeat serious violence, less recorded knife crime, and prevention of serious injury and loss of life. Local multi-agency data, including *Most Serious Violence* rates, are further used to inform programme implementation and areas of greatest need.

Evaluation

Liverpool John Moores University (LJMU) have been commissioned to undertake an evaluation of the Hampshire and Isle of Wight (ED/SP/111) Navigator programme that is being implemented by No Limits. Specifically, the evaluation focuses upon those elements of the programme that are funded by Hampshire and Isle of Wight VRU; namely the ED and social prescribing (SP) functions of the programme[2]. The current evaluation aims to explore and assess how the Hampshire Navigator programme has been implemented and identify what is the feasibility, acceptability and impact of the programme for CYP, programme implementers and wider stakeholders. Evaluation activities undertaken included:

- Desk based review (scoping and mapping exercise) and development of a Theory of Change.
- Interviews with key stakeholders - three paired interviews and two one-to-one interviews with eight individuals involved in the commissioning, design, delivery and implementation of the

[1] The initial ED service started early 2020, in Southampton UHS, this was then followed by Portsmouth Queen Alexandra (QA) Hospital in early 2021, then HHFT and IOW later that year.

[2] The 111 element of the programme is funded by Hampshire and Isle of Wight Integrated Care Board.

No Limits (ED/SP/111) Navigator programme. Six interviews with wider stakeholders, e.g., referral partners and staff based within the hospitals (e.g., ED staff [adult and children's], third sector community advice and mental health crisis support services) to explore: their experiences of working with the Youth Workers, supporting and impeding factors to implementation (and if and how impeding factors were addressed), areas for development, actual and anticipated intervention outputs and impacts, and programme sustainability.

- Analysis and review of secondary data/documentation collected/produced by No Limits.

Key findings and recommendations

Implementation

Delivery, programme recruitment and support pathways

The No Limits (ED/SP/111) Navigator programme works with individuals aged 11-25 years who present at the EDs across Hampshire and Isle of Wight. The programme is a hospital-based violence prevention programme that seeks to support and engage those who present at hospital having experienced violence or being at-risk of violence, crime or criminal activity (e.g., drugs, gun crime, county lines, exploitation) or presenting with other related vulnerability (e.g., substance use, mental health issues [eating disorders], homelessness, and runaways). High levels of those who present at the EDs and engage with the ED Youth Workers and subsequently the SP programme have mental health issues (e.g., attempted suicide, self-harm, eating disorders, anxiety etc.). This is evident in both the quantitative data and interviews undertaken with stakeholders who highlighted they aim to provide holistic and tailored support to the individual that can be around a number of different issues.

> *"I think, certainly that the risk of them becoming victims of criminality is high. I don't think of them be involved as in being offenders themselves is any higher, but the vulnerability side of it I think is more important…We've got full safeguarding here…the vulnerability will be dealt with within the triage [by the nurse] but further supported by the social prescribing that No Limits provided." (WS1)*

The total number of recorded referrals from 1st April 2022 to 11th April 2024 received across all five sites was 1,602. Of all referrals (gender information was available for 1,224 individuals), the majority identified as female (68.0%; n=832), three in ten identified as male (27.4%; n=335), and 4.7% (n=57) identified as non-binary, transsexual, or other. Individuals' neurodiversity, learning needs, long-term conditions and physical disabilities are also captured. 4.8% (n=68) of individuals were recorded as having ADHD, 3.3% (n=46) were neurodivergent, 3.7% (n=60) had educational or behavioural difficulties, 4.1% (n=65) had learning difficulties, 3.2% (n=51) had a long-term illness, 2.0% (n=32) had a physical disability, and 0.7% (n=11) had a sensory impairment.

Risk factors and issues identified for support are assessed on an ongoing basis as the navigator works with each young person. The analysis of the data showed that over half (53.6%; n=858) had risks related to emotional wellbeing, 6.2% (n=99) related to personal safety, 5.2% (n=84) related to substance use, 1.9% (n=30) related to housing circumstances, 1.7% (n=28) related to physical or sexual health concerns, 0.9% (n=15) related to parenting or relationships, 0.9% (n=14) criminal or legal issues, 0.9% (n=14) related to training or study issues, 0.5% (n=8) related to personal development, and 0.2% (n=3) related to income or benefits.

Currently, Youth Workers and two volunteers from the programme as well as NHS staff partners engage with individuals when they are admitted to the ED/a hospital ward. They listen to the young person's experience, identifying any protective factors, and discussing their support needs. Referrals

are then made (via a consent to contact form) from the ED/a hospital ward to the SP arm of the programme. There are also two dedicated Youth Workers who triage referrals sent through from the NHS 111 mental health triage service that is delivered by Southern Mental Health and covers Hampshire and the Isle of Wight. Engaging with individuals at a 'reachable [and teachable] moment' was perceived by professionals as a key 'window of opportunity' for crisis management that can begin to help CYP to realise that there is someone there to listen and empower them to start their support journey. Where CYP do not engage with the ED Youth Worker and/or the SP Youth Worker support, they are provided with key contacts for support (e.g., a 'stay safe' card; leaflets detailing useful self-help apps; a crisis support and looking after your mental health booklet providing information about the No Limits Advice Centre and mental health support; crisis support contact information for other organisations; the mental health pain scale - a tool to help YP explain how they're feeling; and details of Portsmouth support services for U18s, useful apps, tips for helping anxiety etc.). YP may also be referred onto other more appropriate services, such as DASH for support with drug and alcohol use, or homeless charities for support with housing (where SP support may not be appropriate). Whilst there is an approximate 3-4 week wait for SP support to start, the young person is usually contacted within 24 hours of the consent to contact form being completed, which was seen to provide reassurance.

Findings from the monitoring data showed that of the 1,602 referrals during the period April 2022 to April 2024, a total of 10,323 individual actions of support were recorded by the Youth Workers. The average (mean) number of actions per case was six and ranged from one to 94 actions. The average (mean) time spent on each action was 16 minutes but ranged in time from less than one minute up to four hours. The largest number of actions were categorised as support (48.7%; n=5,028), with the next largest actions related to admin tasks (33.1%; n=3,418). 508 actions (4.9%) involved some type of assessment. The remaining 1,369 (13.3%) actions related to appointments with the young person or their family. The majority of actions related directly to the young person (72.6%; n=7,490), whilst 14.3% (n=1,480) were with a family member, friend or another person, and 13.1% (n=1,353) of actions involved work with other professionals.

For each recorded action, several 'events' may be attached to this action. Events refer to the needs for support which are being addressed by a given action. Given each young person may have multiple actions recorded, and multiple events for each action, at this stage it is not feasible to perform a quantitative analysis of events, however, the categories of events recorded for which actions were conducted included: emotional wellbeing, service information, relationships, school, training or studying, physical health, substance use, neglect, violence or exploitation, work, bullying, discrimination or crime, housing, personal development, sexual health, income, benefits or tax, security, stability or being cared for, antisocial behaviour, parenting, budgeting, and community participation.

"There's children that are frequent runaways that we get quite a lot and actually one of my favourite things that No Limits had is a little card that has a QR code that you can scan that will show you a safe place that you can go to that's around you. And so even if a child is not there really to see CAMHS and they're gonna go home from the acute side, I will try to get them one of those cards…there's resources we can give them that can help them when they're outside of hospital as well." (WS3)

Social Prescribing

The SP Youth Workers currently provide a standard four sessions of engagement. These sessions may be undertaken in a hospital setting where a young person may be an inpatient but are typically undertaken in the community through various methods, including telephone, text message, and face-to-face meetings. More recently, this has also included being able to engage with CYP through WhatsApp. This number of sessions was seen to help reduce waiting lists for the programme and provide more structured engagement that has a positive impact for both individuals and Youth Workers. The SP model has always offered four sessions of engagement, with increases in engagement not being due to procedural change, but instead due to the organic needs of the CYP (averaging around six to eight sessions). Some were extended beyond this where there were safeguarding concerns or complex needs with no other organisations available to take the young person on for support. SP Youth Worker support can include the delivery of brief therapeutic interventions and therefore does not follow a traditional SP model of signposting and referral. The engagement is goals-based and identifies areas where support is needed whilst allowing individuals to be 'reflective' about their current situation. This also helps the Youth Workers to identify areas that may need to be explored further. The adaptable and flexible way in which the Youth Workers engage works to maximise the impact of contact with each individual. Youth Workers also have the ability to develop relationships of trust with individuals because they are not statutory services, and this enables them to act as advocates. Stakeholders spoke about Youth Workers having access to lots of different resources that give individuals the freedom and opportunity to explore and try new things. The duration, frequency and the way in which engagement takes place varies depending on this need.

Key facilitators and barriers

Developing connections

It was clear through the evaluation that good connections and relationships have been established with key partners within the hospital setting and this (along with wider stakeholder relationships) was a key facilitator to the success of the programme. The Youth Workers make themselves visible and are embedded into hospitals. Placing No Limits staff within different teams (e.g., CAMHS and VAST) was seen to provide wrap around care for YP. Joint visits are also undertaken with specialised professionals, bringing their own experiences to enhance support for YP and improving outcomes (e.g., with Youth Workers helping clinical and mental health decision making leading to, e.g., discharge/early discharged [paediatric psychiatric liaison team – PPLT]). Referral partners covered all aspects of health and wellbeing (e.g., mental health, drug and alcohol use, domestic and honour-based violence, sexual health and sexual violence/abuse, neurodiversity, young mum groups, safe house, housing, advice centre etc.). They perceived the Youth Workers as engaging well with them. This ensures that the programme is able to make the most of the resource that is available in each locality. It was evident through the evaluation that there is also a great deal of partnership working that is internal to No Limits, with the Navigator programme and the No Limits Advice Centre and Safe Haven Programme providing wraparound support and facilitating conversations between YP and services. These look to address underlying support needs for YP and can provide more than the standard four SP sessions available through the (ED/SP/111) Navigator Programme. Referrals into Safe Haven can involve more in-depth crisis work (e.g., where self-harm which eliminates them from MHST support but is not high enough to breach for CAMHS), whilst referrals to the Advice Centre may be around a number of support issues such as welfare, mental health, housing and legal advice. Another avenue of support from No Limits is the newly formed MHST (from October 2024), however, this is currently only available in Southampton.

"They work really closely with our CAMHS department…[but] there are times with CAMHS...they sometimes can't go and see a patient until they're medically fit, whereas No Limits can go in and just speak to a young person. The majority of time they will help us if we're, you know, struggling with a patient that just doesn't want to talk or something they've got that time to go and sit with the patient and talk to them, provide fidget toys, provide you know, therapeutic wellness, talk about their services, you know, talk about how they can help." (WS5)

"Communication from the Advice Centre drop in to the VAST team to the ED workers. They can then offer that satellite intensive support with the young person in the hospital ensuring that their voices are heard and they understand all the information and also they get a friendly, welcoming face from No Limits because we're really good at building those trust and relationships with young people." (WS6)

Skills and resources are shared between Youth Workers, and they also provide peer support to each other. Youth Workers also have access to clinical and manager supervision for support. Appropriate training opportunities are also provided for the Youth Workers, and they are also able to request training where they feel it is necessary.

Resource

Resource was identified as a key challenge within delivery of the programme, for example: lack of designated office space for Youth Workers (although this was detailed to have been rectified in one hospital where the staff had been provided with desks and a space to bring the CYP); poor internet access with Youth Workers having to use free NHS-Wi-Fi, which also is not secure when viewing client data; a high turnover of staff in some hospitals creating challenges in terms of accessibility to CYP; and, the need for greater coverage of staffing across the week to reduce 'missed chances for engagement'.

"They basically had a bit of a turnover with staff, but they were always very keen to keep us updated with the new staff. We invite the new staff in here to see what we do." (WS1)

Systemic lack of resource and capacity within services across Hampshire and the Isle of the Wight was also identified as a challenge, with the (ED/SP/111) Navigator programme bridging the gap to accessing services. It was identified that there is a gap in mental health provision, and in certain areas of Hampshire, there is limited community-based support to 'safely refer' YP to. Furthermore, the existing services do not provide long-term or intensive support, resulting in the SP Youth Workers case holding for longer and providing more crisis intervention. There was discussion of the role that a Hub for the under 25s may have (there is currently a Hub in the Southampton No Limits Advice Centre) that would act as an advice and drop-in centre for individuals to provide practical (e.g., bills, welfare benefits and CV writing) and health and wellbeing (e.g., drug and alcohol use, mental health) etc. support. In addition, the role of an experts by experience model and a volunteering pilot programme was discussed as a way in which support for current resource/capacity issues.

"It's been a huge help to us massively because so I also come from social services and they have gone bust in Southampton. So there used to be lots of support in place for these young, vulnerable adults. You know, like the Beehive project. And they used to be more housing and sort of counselling services. That's all been

pulled. There's not anything out there anymore for the sage groups. So it's been really, really difficult. So No Limits have kind of come in at the right time." (WS2)

Future delivery

When exploring future delivery, stakeholders highlighted that the Youth Work model lends itself well to children, but that the benefits and impact of the programme upon younger adults (18-25 years) may not be as clear. It was discussed that there is an aspiration towards an all-age liaison service/team approach that would embed the Youth Workers from the Navigator programme in a team including VCFSE, early intervention/prevention elements and community support options. It was felt that this may also address issues around the estate and lack of designated office space etc.

Stakeholders also discussed promoting and increasing the visibility and awareness around the (ED/SP/111) Navigator programme. They also discussed that if it was possible to increase funding for the programme this could increase the presence of No Limits staff to every day of the week 8am to 8pm.

"I think people are aware that No Limits is there, but I think we need more teaching around what No Limits do. I mean I know because…I work quite closely with them. But I think a lot of people they don't think you know when a young person comes in, 'oh I'll do a No Limits referral'…I mean that's not down to the No Limits team that's down to I think just general you know there's so much going on in emergency department sort of thing I think that but I think more promotion about what aspects they can help with…I think you know, a lot of people don't realise what No Limits do. I think they think it's just a wellness centre and it's not, they cover so much more than just wellness…" (WS5)

There's not enough people to cover service…we would need somebody from like 8 in the morning till potentially like 8 at night. But they don't have that service. They don't have that volume of people to be able to do that." (WS5)

Recommendations for implementation

Based on evaluation findings, a number of recommendations were produced, which aim to strengthen the programme's delivery, ensure appropriate recruitment, and enhance support pathways, thereby maximising its impact.

- Continue to enhance the reach of the programme through engagement and collaboration with key stakeholders who can promote and advocate for the programme and also provide feedback around the programme delivery, making changes in real-time where possible.
- It is important for the programme to continue to embrace the adaptable engagement methods for the SP model, as well as looking at whether additional digital tools, such as secure video calls could also help to enhance access to the SP. Ensure that any delivery methods cater to the diverse cultural and linguistic needs of the target population, ensuring inclusivity.
- All support documents such as the 'stay safe' cards and more recent physical (e.g., booklets)/online resources and support tools should be regularly updated to ensure the information is up to date, but also that they meet the evolving needs of CYP accessing the programme, incorporating feedback from key stakeholders. Keep the materials up to date with current issues, trends, and the latest resources, such as mental health apps or online support communities.

- Build on the existing success of the hospital-based collaborative working practices/relationships and stakeholder collaboration to ensure the maintenance of comprehensive wraparound support. Explore whether/how best practices may be formalised with clinical and mental health staff as standard practice to foster teamwork and also how these practices may be replicated across other locations.
- Continue to develop relationships with wider stakeholders (e.g., community groups) to identify at-risk CYP who may not currently be accessing support through the programme (underserved groups) but would benefit from doing so. This may also be supported through the data.
- Continue to expand the volunteer model and ensure that enhanced training opportunities are provided to volunteers to strengthen their roles in the programme. Look at ways in which to recognise and retain their voluntary commitment. A structured volunteer programme will create additional capacity for non-critical engagement.
- Maintain and expand access to clinical supervision and skills training for Youth Workers. This may include the introduction of specialised training modules focused on trauma-informed care to ensure that the Youth Workers and volunteers have the necessary tools and skills to be able to undertake their roles, whilst also being able to safeguard their own mental health and cope with challenging cases.
- Explore the referral pathways between the programme and other No Limits services (e.g., Advice Centre and Safe Haven).
- Continue to provide SP based upon individual circumstances. Explore whether the current SP offer could be expanded to include more 'case holding' intervention workers who would manage those cases that require longer engagement (e.g., more than the standard four SP sessions; those who are long-term stays on wards) or are more complex. It may be explored how No Limits could partner with internal and/or external organisations to manage these cases collaboratively (e.g., 'holding' referral partners). Any changes to delivery of the model need to ensure that manageable workloads are maintained for the Youth Workers.
- Continue to implement a robust feedback system where YP and stakeholders can share their insights on their experiences with the programme, allowing continuous improvement. This may also involve gaining insight into whether there is an appetite for an 'experts by experience' initiative where former programme participants provide peer support and advocacy.
- In order for the programme to be delivered efficiently and successfully, further exploration is needed to look at how barriers to programme delivery may be addressed. This could include: 1) Dedicated private office space to ensure secure, confidential, and effective client interactions. 2) Developing partnerships with hospitals to co-invest in infrastructure improvements, including secure Wi-Fi access for Youth Workers handling sensitive data – this may include exploring portable and secure internet solutions (e.g., mobile hotspot devices) to eliminate dependence on NHS public Wi-Fi. 3) Looking to address systemic barriers such as accessing alternative services and advocate for increased resources through providing an evidence-base around the impact of the programme.
- Suggestions were made around an all-age liaison service model that integrates prevention, early intervention and community support. Embedding the Youth Workers within this service and having this integration across the ED would enable a greater development of a shared understanding of the different skills and the benefits of this and also that not everything needs to be a clinically led model.
- Engage with funders and commissioning bodies to sustain long-term investment in the (ED/SP/111) Navigator programme. This will include working with funders etc. to advocate for and secure increased funding for programme expansion, e.g., additional staffing and extending operational hours to 7 days a week (8am to 8pm).

Outcomes and impacts

There are clear aims and outcomes of the (ED/SP/111) Navigator programme that are detailed in the programme logic model. These are across the short, medium and longer term and can be seen at individual, family/community and wider systems levels.

It is evident through the qualitative data included in this report that there is an overwhelming feeling that the Navigator programme is achieving a number of hoped for outcomes on an individual, family/community and system level. These focussed around:

- Building positive relationships/developing relationships of trust with YP, helping them to feel supported in discussing aspects of their lives they may not have talked about before (e.g., first disclosures).
- Improving health and wellbeing, e.g., increases in confidence, empowerment, self-esteem, resilience, reduced isolation, improved self-care, through access to/engagement with services, YP with eating disorders beginning to enjoy hobbies and socialising again, with an overall increase in emotional resilience). Findings from the monitoring data showed that of the 118 cases which had pre and post data on the Simple Mental Health Pain Scale, there was a statistically significant decrease in mean score from pre to post assessment (pre, 7.18; post, 4.78; $p<0.001$) indicating a positive change.
- Improved physical health, e.g., reduction in the number of individuals who self-harm, YP reducing or stopping the use of drugs and alcohol, taking prescribed medications more regularly etc.

> *"A YP on the final session of social prescribing shared that the significant progress she had made. YP used to take at least 3.5 grams of weed weekly but shared that she had stopped using weed and it has been almost three months now. She testified that the support from different partners is making a difference in her life and is committed to live a better life." (ED/SP/111 staff, secondary data).*

- Increased school attendance in those with Emotional Based School Avoidance (EBSA).
- The support parents/carers received was perceived as improving relationships between parents and CYP.

> *"You're the only person who has come and spoken to him like he's a human being. He needs so much help and we didn't know where to start. Thank you for showing us the right path." (Parent/family feedback, secondary data).*

The hoped for medium to longer-term outcomes of the programme included reducing violence and admissions to ED with aimed impact of reducing pressures on the health, social care, and criminal justice systems.

> *"…sitting in a meeting, and it's like Consultants and the Head of Safeguarding…our voice is sometimes the loudest in those rooms because with the voice of the young person who either isn't sat in that room or doesn't feel brave enough to talk… we make sure that those young people have got their voice heard in those big rooms." (N4)*

> *"I would also like to say thank you for all that you have helped me with and just for being there for me and listening! You have honestly been a wonderful practitioner who always makes me feel cared for and safe." (Young person, secondary data).*

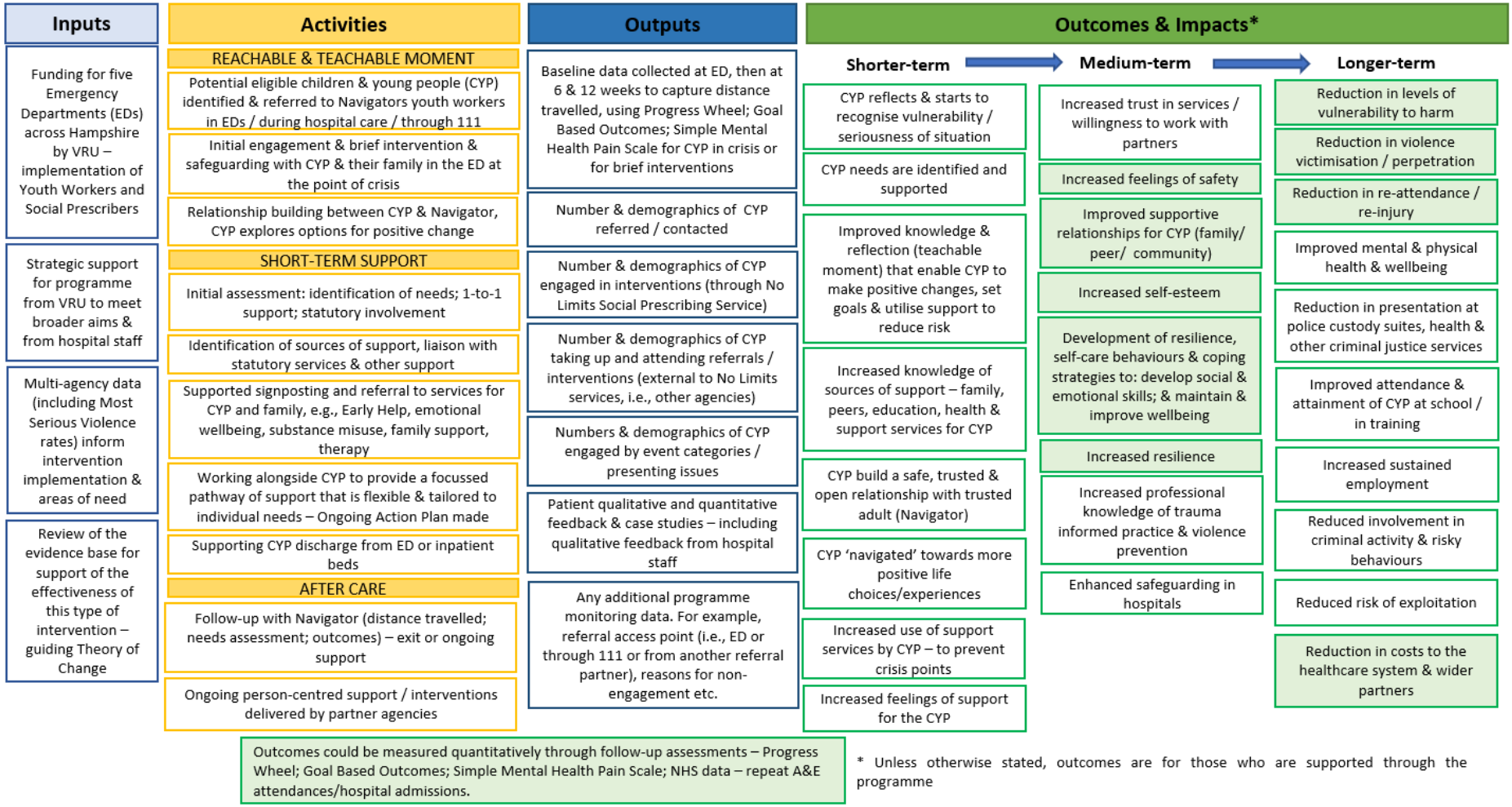
"Early days we had a bit of a challenge of trying to get them [the Youth Workers] integrated within the AMH (adult mental health) liaison service and I think they've done some really good work in terms of building those kind of links." (N7)

Recommendations implementation based on individual, family/community and system level outcomes

Evidence from the evaluation suggested a number of recommendations for the (ED/SP/111) Navigator programme that build upon the programme outcomes.

- Individual level-outcomes can be further strengthened through the continued use of tailored support plans that help to sustain improvements in areas such as self-confidence, resilience and self-care beyond engagement with the Youth Workers. It may also be explored whether with additional resource, access to therapeutic services (e.g., group therapy, peer support networks) may be expanded to further reduce self-harm and strengthen resilience. This could be done in collaboration with local mental health services to address gaps in support for those with complex cases.
- On a family/community level, with consideration of resource, workshops or family therapy sessions could be developed to help parents/carers strengthen their relationships with their children. Resources tailored to parents, such as guidance on supporting CYP's mental health and coping strategies for challenging behaviours could be developed. The programme can also continue to build upon partnerships they have developed/are establishing with local schools, youth organisations etc. to identify and support YP with EBSA and other challenges.
- When exploring system-level outcomes in the longer-term, it is important to utilise outcomes data to advocate for additional funding by demonstrating the programme's effectiveness in reducing ED admissions and how the programme may help to alleviate pressures on health, social care and criminal justice systems.
- The evaluation highlighted a level of unmet need regarding mental health provision and findings from the evaluation can support partners to advocate for funding for provision regarding this.

Hampshire and Isle of Wight Navigator (ED/SP/111) Programme – Logic Model



Evaluation and monitoring

Whilst the monitoring data provided further evidence on the dose and reach and impact of the programme to date, there are a number of considerations for its use in future evaluation.

- No Limits run quarterly reports on their data as standard monitoring practice and this aggregated data is then provided to the VRU and the evaluation team. However, as this is collated data it does not lend itself to more complex analyses (e.g. examining associations between variables) or case studies of YP's journeys. Individual level data covering all cases can also be provided by No Limits. However, this requires additional work by No Limits and because of the way the monitoring system works, this individual level data is pulled off the system in separate Excel outputs. Within each of these datasets YP have an ID which can then be used to match their information across datasets. However, this is a lengthy process and is further complicated because within the interactions dataset each interaction is represented as an individual line of data and, in Year 1 of the programme, it had over 10,000 lines of data. Because the dataset included individuals who had accessed the service prior to the current commission, the client ID for each action had to be manually cross-checked against the referrals dataset to ensure they fell within the current commission period and should thus be included in the analysis. Furthermore, for each action several 'events' (i.e. needs addressed by each action) are recorded in a separate dataset as an individual line and, in Year 1 of the programme, there were almost 30,000 lines of data recorded. Due to the number of lines in this dataset it was not possible to manually match event data to client ID to ensure they fell within the current commission period and thus a quantitative analysis of events data was not undertaken. As a result of the data being captured in this way, it is also not possible to link the dose of the intervention each young person receives to other factors such as demographics, reason for presentation, and outcomes. These factors only have implications for evaluation, including the ability to do more complex analyses. However, the primary purpose of monitoring systems such as the one No Limit's uses is for internal monitoring and recording of individuals' data and support provision and for these purposes the system works well. Given the complexity and resource required to extract and analyse this data we present a subset of individual level data analysis from Year 1 in this report.
- Reason for presentation was originally recorded as the reason for presentation to the No Limits support service rather than the reason for presentation to ED. However, this was flagged as being an issue and has now been changed to reason for presentation to ED.
- Identified risks are recorded in the dataset as risk 1, risk 2, risk 3, etc. Rather than a variable for each risk (e.g., emotional wellbeing, safety) which is then recorded as present or absent for YP. Significant data cleaning was undertaken to recode risks into categories in order to perform the analysis. If risks were recorded as present or absent, it would also mean analysis of the level of risk and the action required for each risk for each individual was amenable for analysis. Whilst significant data cleaning is required to understand risks at the individual level, risk data can more easily be pulled off as collated data which details how many CYP experience each risk. Given the complexity and resource required to extract and analyse this data we present a subset of individual level data analysis from Year 1 in this report.
- While data is currently captured by the system on reasons for case closure, this also does not easily lend itself to analysis to inform the evaluation at an individual level. This is because CYP may reengage with the service and so have multiple entries and reasons for exit from the service. This is not a weakness of the monitoring system, but a factor of the nature of service provision that YP may engage for a period for support and then reengage at a later time point.

- A case record is only created for individuals who work with the social prescribing team. Individuals who are referred but are only seen in the ED do not have a case record created due to the briefness of the interaction and so less detailed information is captured on these YP. This makes sense considering the ED teams may only meet a YP briefly on one or two occasions and capturing and recording this information would involve taking up time that could be better spent delivering the brief intervention. A flag on individuals who only received support in the ED would support more in-depth analysis of any differences between individuals receiving the ED brief intervention and those accessing further support with the SP team.
- Initially, there was consideration of using WEMWBS and SWEMWBS to monitor mental wellbeing outcomes, however, anecdotal evidence from Youth Workers suggested that YP did not like completing this measure and Youth Workers perceived the collecting of this data as a barrier to building a trusted relationship with the young person. This is an important consideration when using outcome measures as part of monitoring data. A balance must be found between measures which are acceptable to YP and informs their support provision and those which will provide evidence of impact. Following a service review of the outcome measures which could be collected, the decision was made to use the Simple Mental Health Pain Scale (in the ED) and the Progress Wheel (in SP). Whilst the Simple Mental Health Scale is not a robust outcome measurement tool, it is appropriate for use in the ED where after a brief intervention other tools which measure impact are unlikely to show change (e.g. SWEMWBS, the Progress Wheel).
- Other ED Navigator programmes have added a Youth Worker assessment of risk/needs at case closure to provide another measure of impact. These can be done jointly with the young person or based on the Youth Workers' knowledge. Another potential data field which could be captured and would be useful for informing the risk profile of individuals accessing the service is if they had ever attended an ED in the past five years for assault-related injury.

Contents

1. Introduction

Interpersonal violence is a global public health issue that has serious consequences across the life course for individuals (World Health Organization [WHO], 2014). It impacts not only the individual, but families and communities. It also impacts the wider system through burdens placed on, for example, health, criminal justice, social services and other sectors. Prevention of and responding to interpersonal violence is therefore an important priority. A public health approach to violence has been adopted by the WHO, which promotes population-level health and wellbeing through addressing the underlying risk factors which are known to increase the likelihood of violence, and also promoting protective factors. The key steps in this approach include defining and understanding the problem, identifying what works to prevent and respond to violence, and implementing (and monitoring/evaluating) evidence-based interventions (Local Government Association [LGA], 2018). In the United Kingdom (UK), preventing violence following a public health approach is a key priority set out in the Serious Violence Strategy (HM Government, 2018), through the development and implementation of a broad range of whole-system (e.g., Violence Reduction Units) and place-based approaches. Hospital-based youth violence intervention programmes (YVIP) are one such approach.

Navigator programmes are hospital-based violence prevention programmes that typically involve Youth Workers working in hospital settings (particularly Emergency Departments [EDs]) to support and engage CYP who present at hospital having experienced violence or being at risk of violence, or presenting with other related vulnerability (e.g., substance use, mental health issues). These programmes are being delivered as part of a broader suite of interventions following a national response to the prevention of youth violence using a public health approach (Brice and Boyle, 2020; Butler et al., 2022; Goodall et al., 2017; Newbury., 2022; The Health Foundation, 2020). Navigators work in a person-centred way utilising the 'reachable and teachable moment' (wherein CYP may be particularly responsive to behaviour change interventions), to engage CYP, identifying their support needs, and co-creating an action plan that is flexible and tailored to support their specific needs. Navigators build trust and develop a relationship with CYP (and their families), providing support for immediate crisis points, and short and longer-term goals. Navigators will signpost and refer CYP to support services where appropriate (e.g., for mental health and wellbeing, substance use, family support), and when necessary, to statutory services for safeguarding.

A review of studies of interventions in North America suggests that ED-based violence intervention programmes may be effective in reducing violence re-victimisation and perpetration (Brice and Boyle, 2020). However, findings are not consistent across all studies, with potential contextual factors of programme implementation, content, and delivery impacting results. Evaluations of similar programmes in the UK have shown that implementation of Youth Workers in busy EDs, while generally positive, was not without challenges. Such challenges included a lack of capacity to meet high and growing demand, difficulties in retaining and recruiting new staff, a lack of capacity in external support services to take on more CYP (such as mental health support), difficulties in multiagency working with external services and challenges posed by short-term funding (Butler et al., 2022; Newbury., 2022; Quigg et al., 2022). A review of studies utilising ED-based Youth Workers to respond to youth violence at the 'teachable moment' found that EDs implementing such programmes must consider several contextual factors in order to be successful, including: understanding the local demographic and

needs, defining what you want to achieve, establishing local strategic buy-in, defining the activities of Youth Workers, introducing training and education for Youth Workers and clinical staff, and planning longer-term funding and sustainability (Wortley and Hagell, 2020).

Evaluations of similar programmes undertaken in the UK have shown that programmes offer a wide range of support, determined by the CYPs' needs, where CYP are referred or signposted to services to address issues such as mental health, substance use and criminality. Programmes improve safeguarding capabilities at hospitals and the knowledge of staff about a trauma-informed approach. Fewer CYP are discharged without any support in place, reducing the degree of 'hidden harms' through improved identification of CYP with unmet needs (Goodall et al., 2017; Newbury, 2022). Children and young people can also benefit from the formation of trusted relationships with Youth Workers, with evidence of improved wellbeing and self-esteem, increased protective factors against violence and reduced levels of risk (Butler et al., 2022; Quigg et al., 2022). The Youth Endowment Fund Toolkit, which aims to collate evidence on approaches to preventing violence, suggests that Navigator programmes may be effective in preventing violent crime (YEF, 2022). However, whilst evidence on the development, implementation, and impacts of such programmes is starting to emerge, the evidence of effectiveness is currently of low quality and further evaluation is needed (Brice and Boyle, 2020; YEF, 2022).

Hampshire and Isle of Wight Hospital Navigator Programme

Since 2022, five ED departments across Hampshire and Isle of Wight (Basingstoke, Isle of Wight, Portsmouth, Southampton and Winchester) have been funded by Hampshire and Isle of Wight VRU to implement a Navigator programme, utilising Youth Workers and social prescribers[3]. The implementation of these workers is supported strategically by the Hampshire and Isle of Wight VRU, with their implementation part of an approach to meet the joint broader aims of the VRU, including: reduction in vulnerabilities and vulnerable people; reduction in repeat serious violence; less recorded knife crime; and prevention of serious injury and loss of life. Local multi-agency data, including *Most Serious Violence* rates, are further used to inform programme implementation and areas of greatest need.

There are several hoped for impacts of the Navigator programme including:

- Help CYP reflect and recognise the seriousness of their current situation and any associated vulnerability.
- Increase feelings of support through identifying the needs of CYP and the support they require, providing CYP with increased knowledge and awareness of support services they can access, and helping CYP to build safe and trusting relationships with the Navigator (Youth Worker) and other professionals.
- Increase feelings of trust between the CYP and Navigators (Youth Workers), leading to an increased willingness to work with services.
- Help CYP to develop resilience, self-care behaviours, and coping strategies, leading to increased confidence, self-esteem, and feelings of safety.

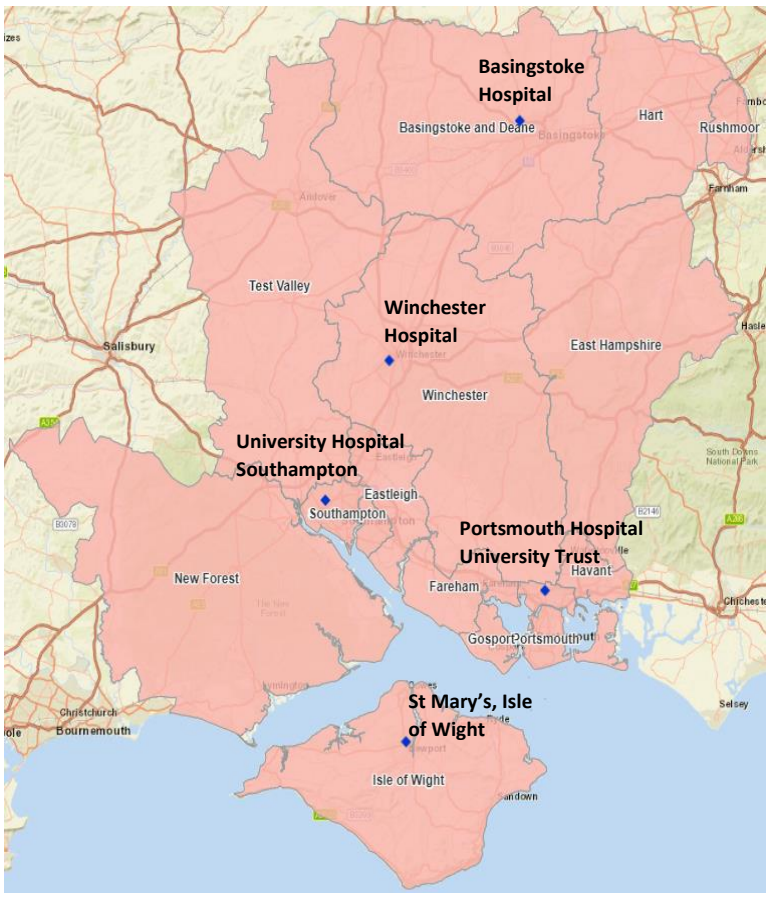
[3] The initial ED service started early 2020, in Southampton UHS, this was then followed by Portsmouth QA in early 2021, then HHFT and IOW later that year.

- Reduce CYPs' vulnerability to harm, including experiences of violence and risky or criminal behaviours, which may lead to reduced presentations at services such as health or police and improved mental and physical health and wellbeing.

The current evaluation aims to explore and assess how the Hampshire Navigator programme has been implemented and identify the feasibility, acceptability and impact of the programme for CYP, programme implementers, and wider stakeholders. Specifically, the evaluation focuses upon those elements of the programme that are funded by Hampshire and Isle of Wight VRU; namely the ED and social prescribing (SP) functions of the programme[4].

The NHS site locations for the Navigator programme include Basingstoke Hospital, Basingstoke and Deane; Winchester Hospital, Winchester; University Hospital Southampton, Southampton; Portsmouth Hospital University Trust (QA), Portsmouth; St Mary's, Isle of Wight (Figure 1). The key demographics of these five areas can be seen in Table 1.

Figure 1: Location of Navigator programme NHS sites



[4] The 111 element of the programme is funded by Hampshire and Isle of Wight Integrated Care Board.

Table 1: Key demographics, including violence related statistics for the five Navigator NHS locations [5, 6, 7]

Local authority	Demographics and violent crime statistics
Basingstoke and Deane	• **Population:** 185,656; 50.5% female, 49.5% male; 17.9% 0-16 years, 64.7% 17-64 years, 17.4% 65+ years; 88.5% White, 5.9% Asian, 2.0% Black, 3.6% other ethnicities. • **Deprivation:** IMD average score 12.8 (243rd most deprived in England). 0.0% LSOAs in top 10% deprived nationally. • **Violent crime:** rate of violence and sexual offences per 1,000 population in May 2023 2.2 (across all LAs in South East – lowest 1.2, mean 2.6, highest 5.2).
Isle of Wight	• **Population:** 140,889; 51.5% female, 48.5% male; 13.8% 0-16 years, 56.9% 17-64 years, 29.3% 65+ years; 97.0% White, 1.2% Asian, 0.3% Black, 1.5% other ethnicities. • **Deprivation:** IMD average score 23.3 (98th most deprived in England). 3.4% LSOAs in top 10% deprived nationally. • **Violent crime:** rate of violence and sexual offences per 1,000 population in May 2023 3.7 (across all LAs in South East – lowest 1.2, mean 2.6, highest 5.2).
Portsmouth	• **Population:** 206,828; 50.4% female, 49.6% male; 16.9% 0-16 years, 68.1% 17-64 years, 15.0% 65+ years; 85.2% White, 6.9% Asian, 3.4% Black, 4.4% other ethnicities. • **Deprivation:** IMD average score 26.9 (59th most deprived in England). 12.0% LSOAs in top 10% deprived nationally. • **Violent crime:** rate of violence and sexual offences per 1,000 population in May 2023 5.2 (across all LAs in South East – lowest 1.2, mean 2.6, highest 5.2).
Southampton	• **Population:** 247,256; 49.8% female, 50.2% male; 17.0% 0-16 years, 69.1% 17-64 years, 13.9% 65+ years; 80.7% White, 10.6% Asian, 3.0% Black, 5.6% other ethnicities. • **Deprivation:** IMD average score 26.9 (61st most deprived in England). 12.8% LSOAs in top 10% deprived nationally. • **Violent crime:** rate of violence and sexual offences per 1,000 population in May 2023 4.7 (across all LAs in South East – lowest 1.2, mean 2.6, highest 5.2).
Winchester	• **Population:** 127,916; 51.1% female, 48.9% male; 16.5% 0-16 years, 62.5% 17-64 years, 20.9% 65+ years; 93.6% White, 3.1% Asian, 0.6% Black, 2.7% other ethnicities. • **Deprivation:** IMD average score 9.6 (292nd most deprived in England). 0.0% LSOAs in top 10% deprived nationally. • **Violent crime:** rate of violence and sexual offences per 1,000 population in May 2023 1.9 (across all LAs in South East – lowest 1.2, mean 2.6, highest 5.2).

[5] All location demographics found at this source: https://www.varbes.com/demographics/isle-of-wight-demographics

[6] All deprivation statistics from IMD 2019: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

[7] All violence rates statistics from this source: https://lginform.local.gov.uk/reports/lgastandard?mod-metric=19593&mod-area=E06000046&mod-group=AllLaInRegion&mod-type=namedComparisonGroup&mod-period=6&mod-groupType=comparisonGroupType

2. Evaluation Activities

Evaluation aims and objectives

The Public Health Institute, LJMU was commissioned to undertake an evaluation of the Hampshire and Isle of Wight Hospital Navigator programme. The evaluation included a mobilisation, scoping, design and feasibility stage, followed by the implementation of a service evaluation.

The service evaluation aims to monitor, document, and describe the implementation of the programme including content and delivery, dose and reach, factors supporting and impeding implementation, and areas for development and sustainability. A mixed-methods approach was used to explore:

- How much of the programme is being delivered (dose)?
- What is the uptake of the programme amongst the target population (reach)?
- How is the programme being implemented?
- Is the programme being implemented as expected and intended (fidelity)?
- What aspects of the programme have worked well or not worked well?
- How could dose, delivery, uptake and reach of the programme be improved?
- What are the mechanisms of change, for whom and why?
- What impact does the intervention have on service users (e.g., violence, risk/protective factors)?
- If feasible, what impact does the intervention have on service demand (e.g. A&E attendances/hospital admissions)?

Evaluation activities

Scoping activities

Ethical approval was obtained from the LJMU Research Ethics Committee prior to the study commencing (23/PHI/019). The evaluation mobilisation began with a comprehensive scoping, design, and feasibility stage. Scoping activities were carried out to build relationships with the Office of the Police and Crime Commissioner (OPCC)/VRU, and No Limits to understand the anticipated intervention activities and outputs, and short/long-term impacts; these aspects informed the evaluation design and included:

- Desk review of intervention documentation.
- Online scoping workshop and meetings with the steering group, VRU, and No Limits to understand the planned intervention and aimed outcomes and inform the focus and feasibility of the evaluation.
- The development of an evaluation logic model to identify activities, outputs and aimed outcomes of the programme. The logic model informed the evaluation design and provided a framework to guide data collection (including methods and measures) and analysis/reporting throughout the evaluation period.

Stakeholder interviews

In-depth semi-structured interviews were conducted online (via MS Teams) (three paired interviews and two one-to-one interviews) with eight individuals who were involved in the commissioning,

design, delivery and implementation of the No Limits (ED/SP/111) Navigator programme. The interviews explored the background to the intervention; experiences of, and progress in implementing the intervention across Hampshire and the Isle of Wight, and within each implementation site/community partner; supporting and impeding factors to implementation (and if and how impeding factors were addressed); areas for development; actual and anticipated intervention outputs and impacts; and programme sustainability. All participants were provided with a participant information sheet that outlined the purpose of the research and all participants were required to give consent to take part.

Site approval was gained from the four NHS Hospital Trusts involved in order to carry out data collection with key stakeholders who are detailed below. An additional six semi-structured online (via MS Teams) interviews were undertaken with wider stakeholders, e.g., referral partners and staff based within the hospitals (e.g., ED staff [adult and children's], third sector community advice and mental health crisis support services) to explore their experiences of working with the Youth Workers; supporting and impeding factors to implementation (and if and how impeding factors were addressed); areas for development; actual and anticipated intervention outputs and impacts; and programme sustainability.

Despite attempts from the research team, programme leads at No Limits, and the Youth Workers, it was not possible for the evaluation team to directly engage with any of the CYP accessing the service or their parents/carers to speak to them about their experiences. In light of this, we have used secondary data collected by No Limits to provide examples of the voices of CYP and their parents/carers. We have also incorporated a number of case studies (only in those cases where the young people have given their permission for their case study to be shared more widely than with just the No Limits team). There was also an LJMU survey available to all CYP (aged 14+ years) be completed at the end of their support. Only one CYP completed this survey and it has not been included in the analysis as it would be identifiable to the Youth Worker who would be aware that the young person had completed it.

Review and analysis of programme monitoring data

Programme monitoring data collected by No Limits on their internal database was accessed and reviewed to understand programme dose and reach, and support activities. This data was only available for the period April 2022 to April 2024. The monitoring data includes CYP demographics, and disability, neurodivergence, and health issues. Reasons for presentation to the (ED/SP/111) Navigator Programme is also recorded. In addition, data on types and levels (low, medium, high) of risk which CYP were experiencing were also available. The monitoring data also includes use of: 1) the Simple Mental Health Pain Scale (SMHPS)[8], which captures mental and emotional distress[9]. This measure is scored on a scale of 1 to 10, whereby increasing scores represent increasing issues. It is completed at initial assessment and at subsequent assessments (including the end assessment). 2) The Progress Wheel, which looks at 10 different areas where an individual may have specific needs to be addressed[10].

[8] https://thegracefulpatient.wordpress.com/2017/12/15/a-simple-mental-health-pain-scale/

[9] This is available for a subset of young people as the scale was only introduced in 2023.

[10]The Progress Wheel looks at 10 different areas (e.g., emotional wellbeing , relationships and parenting, housing, income, substance use, physical and sexual health, study and work, crime and legal issues, personal development and participation, and personal safety) where an individual may have specific needs and throughout their engagement with the programme they will look to address these needs through signposting, referral and advocacy and the individual and Youth Worker can see how far they have progressed. A Progress Wheel will also be completed on discharge.

All programme monitoring data presented in this report should be considered in light of the limitations with programme monitoring data, which is not necessarily designed for evaluation purposes. These limitations are detailed in Section 6 and where relevant as footnotes throughout the report.

Data analyses

All interviews were digitally recorded, fully transcribed with identifiers removed and coded for thematic framework analyses. This detailed the process of programme implementation and identified key themes relating to facilitators, challenges, and impacts of the programme. The analysis is presented with illustrative quotes where appropriate to highlight key findings.

Quantitative analysis was undertaken in SPSS (v. 28) using descriptive statistics. Cross-tabulation was used to examine the integrity of the linked data fields to inform the assessment of data quality and capture. Where data was available to match CYP's scores on their initial SMHPS and their end assessment, paired sample t-tests were used to identify statistically significant changes.

3. Findings

3.1 Overview of the No Limits (ED/SP/111) Navigator programme

Delivery sites and team structure

In Hampshire and the Isle of Wight, the No Limits (ED/SP/111) Navigator programme runs within the EDs at[11]:

- Basingstoke Hospital and Winchester Hospital (Hampshire Hospital Foundation Trust) - 1 Lead Youth Worker, 2 Youth Workers, 1 ED volunteer.
- University Hospital Southampton - 1 Lead Youth Worker and 2 Youth Workers.
- Portsmouth Hospital University Trust (QA)- 1 Lead Youth Worker and 3 Youth Workers, 1 ED volunteer.
- St Mary's on the Isle of Wight - 1 Youth Worker.
- 111 – 2 Youth Workers

These EDs are situated in serious violence hotspot areas.

The Youth Workers work both full and part-time across different shift patterns and typically split their time between working in the ED, as well as having a caseload where they provide follow on support through the Social Prescribing (SP) arm of the programme.

> *"…we'll try to do 7-day coverage wherever possible. We have a mixture of evenings, weekends and daytime shifts as well. So if there's a Youth Worker on site, then any of the hospital staff can go and find them or they're usually wandering around in the ED anyway, or up on the wards. But they also have access to the hospital system so they can check to see if there's any young people within our age range that have been admitted into ED." (N1)*

A volunteer model was introduced in Quarter 2 (2024/25). Currently, there is one volunteer who is based at Basingstoke who undertakes 3 x 3 hour shifts, with No Limits looking to further increase the volunteer capacity across the service, leading to a long-term volunteer model. For this volunteer, they were seen to have been *"nurtured and supported by an effective system of induction and training, shadowing and mentoring and ongoing professional development." (ED/SP/111 secondary data)*.

The service also had their first Social Work student placement from Solent University (September 2024-February 2025) on a full-time basis – after their initial training period had been completed, they supported the SP111 Team twice a week and Portsmouth QA Hospital ED/SP 3 days a week.

There are also two dedicated Youth Workers who triage referrals that are received from the 111 mental health triage service, which is commissioned by Southern Mental Health and covers Hampshire and the Isle of Wight.

[11] These staffing levels were correct at the beginning of 2025.

Programme aim and eligibility criteria

The aims of the programme are to:

- Support CYP and their families at the time of crisis when presenting at ED.
- Provide support at peak admission times for CYP, identified by the ED.
- Work alongside CYP to provide a focussed pathway of support that is flexible and tailored to individual needs.
- Support the discharge of CYP from ED and other inpatient beds (where appropriate).

Whilst there is a focus around those aged 11-25 years who are admitted to ED due to being involved in/being victims of violence, crime or criminal activity (e.g., drugs, gun crime, county lines, exploitation), the programme also provides support to those presenting with other related vulnerabilities (e.g., runaways, poor mental health, eating disorders) and anyone who wants to engage with a Youth Worker. Having No Limits staff being based within the hospital seen as a 'huge help'.

> *"We work with children and young people aged 11 to 25 that come in crisis and that varies for whatever their presenting issue be whether it's overdose, deliberate self-harm and we've got a lot of alcohol use, assault. Our assaults and victims of crime has massively increased…primarily a lot of it is mental health and alcohol and the assault sort of victims at the minute…if we see a young person that maybe sort of has a scald or burn…or a bump to the head. We [might] think right let's go and have a chat with them and see what we can unfold there. It may be you know, nothing to worry about, but also may open, open up a can of worms I suppose." (N8)*

> *"…they're [No Limits] able to follow children. So if we get kids that come in or even as some adults that come in and they get admitted, they can do follow up so that it's not just within the emergency department…if they go to the acute assessment unit upstairs or the AMU department around the corner, they can go and see them [the patient]… [they can] keep an eye on them…if they get that chance to build that relationship, they can, you know, sometimes help the medical teams… So they are really good at helping us. They will, obviously, you know, uncover some things that we don't…(WS5)*

Stakeholders spoke about placement of the No Limits staff within different teams in the hospitals, e.g., Child and Adolescent Mental Health Services (CAMHS) and the Vulnerable Adult Support Team (VAST), and the benefits associated with this in that it enables an integrated approach and wraparound care and support of CYP.

> *"We put ourselves in with the hospital CAMHS team…very often we'll see somebody on the ward or in the ED that they've got to do formal assessment on a little bit later. So we'll do a bit of overlapping or they'll say we've seen this person down on the ward I think No Limits could really signpost for them, do some advocacy, do some social prescribing… It's quite an integrated approach…and it's not called the CAMHS team at the hospital it's Paediatrics Psychiatric Liaison… the PPL team." (N9)*

> *"We've been working jointly…now they're based within the hospital it has been a huge help because before we used to do online referrals and then we didn't really know what happened with that. So now we do joint visits…So if a patient comes*

through who's a 20 year old, then we will contact No Limits and then we will do that joint visit together and then we bring different experiences and different tools and different services as well because No Limits case manage where we only work with them whilst they're in the hospital. So not only are they getting that input whilst in hospital, we start that process and then No Limits will continue to support them when they get discharged. So it's like that full holistic approach then for the patients and not just the patients, it's the families as well." (WS2)

Programme recruitment process and support pathways

Youth Worker/volunteer engagement in the ED

Youth Workers and the volunteer make initial contact with individuals when they are admitted to the ED (See Appendix 1 for Social Prescribing referral pathway). Here they will speak to the individual to try and ascertain what has brought them to the ED (listening to their backstory and identifying protective factors) and whether they would like any additional support. This initial contact was seen as a 'window of opportunity' for crisis management, with CYP people being given a 'listening ear' and 'hope' and 'direction' that can begin to empower CYP and 'keep them going' whilst they wait for support from other services. The Youth Worker/volunteer will either complete *a consent to contact* form for the SP programme (if the individual has agreed they would like further support) or refer/signpost them directly to other services where more appropriate, for example, the Drug and Alcohol Support Hub (DASH), homeless charities (in the context of increasing numbers of homeless young people presenting at ED).

"…the intervention could be as short as speaking to a young person once they've been in ED, giving them brief interventions there and then, or signposting while they're in ED. Sometimes we might only have 5-10 minutes with a young person and all that piece of work may be done within that short, brief intervention…[those] reachable teachable moments. So it was in the point of crisis to be able to give that young person and their families…that information to be able to, for them to use either on their own or to re-engage once they've been discharged with the social prescriber." (N1)

"…every individual is different and they'll have different needs. They'll have different issues and struggles…what might work for one won't work for another… they may have already received support and it might be negative…so it's trying to work around that and trying to put a positive spin on the support that they can get." (N8)

"[in the AAU – Acute Assessment Unit] we can do some initial signposts in there and some there was one of the clients sofa surfing and intermittently sleeping rough and were able to in that moment, sit with him and do a direct referral to one of the local homeless charities who also did some other supplementary counselling support…And then obviously there's a safeguarding issues and we're linked with quite closely with the hospital safeguarding team. So if we've got any concerns, you get to know the people in the hospitals, so it's almost like an extended arm of the staff." (N9)

Where an individual approached in the ED declines further support, the Youth Worker will provide them with key leaflets and a 'stay safe' card with key contacts for support outside of the ED, e.g., Papyrus if they have attended the ED for their mental health, suicidal ideation, or overdose. There is

also a QR code that CYP can scan and find a 'safe place', which is seen as an intermediate measure, working towards preventative harm reduction. More recently (Q2 2024/25), No Limits have also produced a number of additional support resources including: a leaflet with details of useful self-help apps; crisis support and looking after your mental health booklet providing information about the No Limits Advice Centre and mental health support, crisis support contact information for other organisations, the mental health pain scale as a tool to help YP explain how they're feeling; and details of Portsmouth support services for U18s, useful apps, tips for helping anxiety etc. It was highlighted that it is important to provide enough information for the individual should they be in crisis and need support, but not too much that will be overwhelming and it will be 'slung in the bin'. There is also the option for individuals to contact the Youth Worker after they have been discharged.

> *"…A person absolutely needs to be able to consent to the care and support and treatment that they're being given. And I think if that person is happy to sit down and have that conversation and open up their heart and talk about their sort of needs [that's a good thing]..." (N6)*

> *"There's children that are frequent runaways that we get quite a lot and actually one of my favourite things that No Limits had is a little card that has a QR code that you can scan that will show you a safe place that you can go to that's around you. And so even if a child is not there really to see CAMHS and they're gonna go home from the acute side, I will try to get them one of those cards…there's resources we can give them that can help them when they're outside of hospital as well." (WS3)*

Where a Youth Worker is not available at the time an individual is admitted to the ED, consent to contact forms can be completed by professionals within the hospital in the ED, from the wards or from other professionals based within the hospitals, such as CAMHS and Adult Safeguarding as well as substance use teams etc.[12] .

> *"We've got the consent forms in our office for No Limits. We get that consent form filled out and then we will refer on online and we've started since I've been in this post…since April. But I've started to build a rapport with the advice centre in Southampton as well, so we know who to go through if we've got domestic violence that comes in and we've got no practitioners on site." (WS2)*

Stakeholders spoke about the fast-paced environment in ED, noting that when a young person is medically cleared, admitted to a ward, or discharged, there is 'pressure' for a quick turnaround with putting support plans in place.

> *"It's a fast turnaround in ED. That's the thing. So what happens is the patient will get seen from a medical point of view and when they're medically cleared or we've got a plan, if they're being admitted or they're being discharged, then they [No Limits] will come to us to sort out the psychosocial problems. But there's always that quick turnaround because we need that constant flow of the*

[12] In Q3 2024/45, the service began trialling the use of online rather than paper-based consent to contact referrals for ED staff to complete. This was trialled firstly at UHS, with feedback sought from ED staff, VAST and CAMHS. From these discussions and feedback, it was decided that Microsoft forms would be used and was rolled out across the other Hampshire and Isle of Wight EDs. Using a Microsoft form was seen to help ensure more secure processing of information, holding the submitter accountable, and helps the team to process the referrals quicker, resulting in less inappropriate referrals or referrals missing demographic data.

emergency departments. There's quite a lot of pressure to kind of get those plans in place quickly." (WS2)

Children and young people may also be identified through the NHS 111 mental health triage service. An example given by one stakeholder for the month of August 2024 showed that of 350 calls that were received through the mental health triage service, approximately 40-50 referrals were made to the No Limits SP programme for reasons such as depression, ADHD, housing, finance, or exam pressure/stress. Being able to offer referral into the service was perceived as important.

"If my son phoned in and got a triage, would I want him to have the support from No Limits? The answer is yes, because they understand where they are… you know they understand it and it's better coming from them from a social prescribing [service]. You know, I see. I see you. I know where you are. I understand you. I mean, I'm not saying the nurses can't do it [at NHS 111], but I think No Limits have got that understanding of young people, which is just right, at the right time, with the right option. (WS1)

The Social Prescribing Programme

The *consent to contact* forms are triaged by the Lead Youth Worker at each of the sites, including NHS 111 to explore support needs as well as ensuring the referral is suitable. Where they are not, onward signposting or referral is provided. For those individuals who go on to receive the SP support, the Youth Worker will call or introduce themselves via text and then book in a time to speak face-to-face where possible.

The No Limits SPs will contact the young person within 24 hours of the consent to contact form being completed, and this will include telling them when they are able to start SP support (approximately a 3-4 week wait). This was seen to provide reassurance and earlier support than would otherwise be provided by other services.

"The nurse will explain where they referred them say, into CAMHS…if they're over 18, it'll be into Crisis…They may not have an update from that as quite as quickly as No Limits [who] will get back to them…within 24 hours. They've got at least that reassurance that they're going to get that contact." (WS1)

In the initial SP contact, the needs of the individual are discussed – their current situation, triggers and stresses, health and wellbeing support and identification of activities that might be appropriate. This is seen to provide the young person with a 'needs-led' approach and *"that sense of openness…a sense of freedom to kind of explore, see what they'd like to do. They may even want to try something that they've never tried before" (N3).* It was felt that it can take time to establish what these needs are, but that the Youth Workers have a lot of resources at their fingertips (e.g., games, wellbeing journals) to provide immediate support and ways in which to encourage individuals to engage, whilst also acknowledging that sometimes an immediate onward referral is needed.

"I think sometimes that can be a little bit difficult for a young person to find out what it is they actually need. And we won't necessarily just pick the most important one. We will help with as much as we can and if we need to refer onward because that's not best place sitting with us, then we'll do that as well. But we've got a lot of resources that we go through. We've got well-being journals, which young people absolutely love to be able to sort of track their

progress and talking about. Positives and negatives and things in their lives…" (N2)

''The No Limits team go the extra mile for the young people, I've seen nails being painted, trips to Costa and many games being played, the patients and the staff are so grateful for the time they have to give them.'' (Professional feedback, secondary data)

It was discussed that the SP programme is focussed on goals-based outcomes that are identified using the Progress Review, with clear expectations and boundaries set between both the individual and Youth Worker in terms of engagement and what is possible/not possible set in the initial session. It was felt that using tools such as the Progress Wheel enables individuals to identify areas they may need support and to be 'reflective' about their current situation, but also that it helps the Youth Workers to identify areas that may need to be explored further. It was also highlighted that an appropriate plan is always in place when the service is 'closed'[13], that will include suitable signposting and onward referral for the individual (and their family where applicable).

"We have a Progress Wheel…it covers lots of different areas within their life….we go through each of those areas and we get them to score it from 1 to 10. So 10 is, there's no concerns. One is [I'm] really stuck with this…doing that assessment means that we then pick up on what they've identified as issues…but also what it does is we then talk about certain things they might have scored something like an eight, but then they've told you something that's a bit concerning and you go, oh, let's just like explore that a little bit more…"(N4)

"We always make sure that there is an appropriate plan in place when we're closing our service to the young person…[identifying] who's going to be there to support the young person, what their sort of progress looks like and also always making it clear that they can always be referred back into the service and sort of a lot of signposting. Crisis numbers and things like that, that will go out to the young person and their family members as well." (N2)

Stakeholders commented that the Youth Workers go 'over and above' and that the SP sessions enable them to provide therapeutic interventions and support a young person who wants to, for example, attend a dance class until they feel confident enough to go on their own, encouraging engagement.

"I've got a good relationship with the practitioners from No Limits that we've got in ED at the moment and they do a lot. You know they case manage and they go over and above…I think it's amazing, you know, someone who's nervous to go, I don't know to a dance class they're [the SP Youth Worker] going to support them. and you know, really encourage them to attend that dance class….They [the Youth Workers] do [go with them] until they build that confidence, which is amazing because we can't do that as VAST practitioners. You know, we're dealing with it in the acute setting, but if we can reassure them that actually they've got

[13] A case may also be closed: 1) if the Youth Worker contacts an individual and they decline support from the programme at that time; 2) a three-contact rule is employed, whereby if the individual has not engaged within three contacts (e.g., phone call and text contact) the case is closed and the Youth Worker will provide information telling them how they can engage in the future.

that continuing support out in the community as well, it gives them more reason to engage." (WS2)

Onward referral partners

It was highlighted that No Limits subcontract with other organisations where individuals require 'more intensive support'. No Limits also have their own counselling and sexual health services that individuals from the ED SP element of the programme can be referred and signposted into. Other referral partners include schools, who a number of stakeholders commented they are trying to engage with more; as well as other educational provision, CAMHS, mental health liaison teams, Youth Trust, Children in Care Teams, Police Community Support Officers, and VCFSE organisations that look to support the health and wellbeing of CYP and young adults, including youth clubs and those focusing upon drug-related harms, sexual violence (e.g., Independent Sexual Violence Advisors) etc.[14].

"A big part of it is trying to get schools alongside us…we have a lot of young people that find school really challenging…People don't understand they just have all of those different things going on and not feeling that you're understood by your teachers or you're labelled as naughty or you're labelled as kind of dismissive…So actually just advocating for the young people in terms of their school. They spend so much time there. If you've got a trusted person at school or school understanding of, actually you're going through a really difficult time. That's a lot of conversations that we're having, trying to kind of get involved with the pastoral support within schools." (N4)

"…She [the professional] essentially appoints any consent to contact with young people that they've got overlaid to us. And when I first started…I think that was about 10 or 20 within like a month or two, you know, even just starting there was a huge spike in it… there's a few young people that I'm working with that are generally homeschooled because they can't go to school for certain reasons. So you know to kind of see that increase already…it really does sort of open your eyes up to kind of realise that there's sort of a bigger picture going on here." (N3)

Other No Limits Services

It is evident through the evaluation that there is a great deal of internal partnership working within No Limits and a number of services with whom the ED/SP programme works with directly as a referral partner, namely the Advice Centre and Safe Havens. The Advice Centre and Safe Haven are similar in

[14] A full list of specific onward referrals partners detailed through the No Limits monitoring data include: ADHD Support; Aluminia; Andy's Man Club; Aurora; Autism Hampshire; Band of Brothers; BCoT Counselling; BEAT; BRAAIN; Breakout Youth; Bright Beginnings; Calm App; Calm Harm; CAMHS; Catch22; CatchIt; Charlie Waller Trust; Childline; CMHT; DASH; DASS; Early Help; Eastleigh Youth Counselling; Emotional Resilience; EYC; Finch ; elf Care; GP; Hampshire Schools Admissions; Hampshire YOT; Hampton Trust; HHT via CAMHS; Holly Guard; Housing Support; HYA; I Am Sober App; Inclusion; Inclusion Recovers; Isorropia; ITalk; Koala Community Club; Kooth; MIND; Mind Calm; MIND For Parents; Mindspace; Motiv8; MyPositiveSelf; Next Steps; NL 16-25 MHT; NL Advice Centre; NL Counselling; NL Next Steps; NL Work Club; NL Safe Haven; Oasis; Off The Record; Paladin; Papyrus; Paulsgrove Family Hub; Phoenix; PIPPA; Quell; Re:Minds; Revive Community Hub; Romsey Youth; Safe Brighter Futures; Safe Havens; Safe Place; Saints Foundation; Samaritans; SENDIASS; SHINE; Shout; Simon Says; So Linked ; Society of St James; Solent Mind Wellbeing Centre; Southampton MHT; Space4U; Sport in Mind; Star Counselling; Step by Step; Steps2Wellbeing; Sue Ryder; Suicide Prevention UK; Talking Change; Talking Therapies; Teen Safe House; Testbourne Wellbeing Hub; The Lighthouse; The Source for You; The Vine; The Vine Counselling; The Wave Project; Time4U; Treetops; Winchester Youth Counselling; Yellow Brick Road; Yellow Door; Young Minds; Young Mum's Group; Youth in Romsey; Youth Options; YPI Counselling

essence to the ED/SP Programme in that they are looking to address the underlying support needs of CYP and signpost and refer them as needed. Both the Advice Centre and Safe Haven are staffed by Youth Workers and can provide more than the standard four sessions available to CYP through the No Limits SP Programme; and drop-in sessions are also available. It was discussed that with these two provisions, CYP have to travel to them, and in the case of the Advice Centre, the SP Youth Workers can arrange to meet CYP there in addition to being able to travel out to meet CYP in the community, which may be less anxiety provoking as they are in an environment that may be more familiar/comfortable for them.

> *"We work, I suppose, alongside ED and SP really…they are seeing the young people that are reaching ED and in those crises and then they are a referrer to us. So we work quite closely with them around. You know, then referring into us handing over of what's happening with young people, sharing of information, linking in, supporting those young people effectively." (WS4)*

> *"Social prescribers have the base to meet young people centrally in regards of transport links and stuff like that. So they actually when they do meet them at the hospital, they get those referrals. They can actually then engage them back into No Limits by meeting that young person. And some of these young people are new to the service as well." (WS6)*

Both the Advice Centre and Safe Haven were seen to work alongside the ED/SP Youth Workers helping to wrap around support and facilitating conversations between CYP and services. It was discussed how the ED/SP Youth Workers meet and build up relationships with CYP in the ED, who they can then see in the community through the SP side of the programme. Referrals into Safe Haven can involve more in-depth crisis work, whilst referrals to the Advice Centre may be around a number of support issues such as welfare, mental health, housing, and legal advice.

> *"The ED team can directly refer into [Safe Haven] because you know actually you've come to crisis and you're struggling…So it's self-defined crisis. And there's no criteria…You can be under CAMHS or MHST [mental health support team] waiting in between appointments, whatever, it's just about making sure that we support them and those pinch points of crisis and don't escalate. The SP [Youth Worker] comes in [and that is] what I think [works] brilliantly is that the ED team they've met them and they build that relationship in the ED and so then it's like, OK, but let's we've built a bit of a connection here. You've opened up to me about stuff I can come and see you in the community wherever it works for you through the SP work and help signpost them and give them a little bit of support but signpost them into other services. So if they haven't referred or signposted at the point of ED they can do those few interactions through SP and then refer into [Safe Haven] for… a little bit more in depth crisis work and looking a little bit more of that and actually the SP work I might have already done other referrals that we then don't need to do for longer support or liaison CAMHS or what have you." (WS4)*

It was also mentioned that there can be occasions where there is cross-over when the young person may be receiving support from the SP Youth Worker and support from Safe Haven or the Advice Centre for a short period of time. The reason for referral from the ED/SP to Safe Haven are predominantly around post-suicide attempts, heightened anxiety and panic attacks, and self-harm (which eliminates them from MHST support but does not meet the threshold for CAMHS). Other referral reasons are

related to unhealthy relationships, talking to people online, hanging around unsafe places, and increased risk of vulnerability and exploitation.

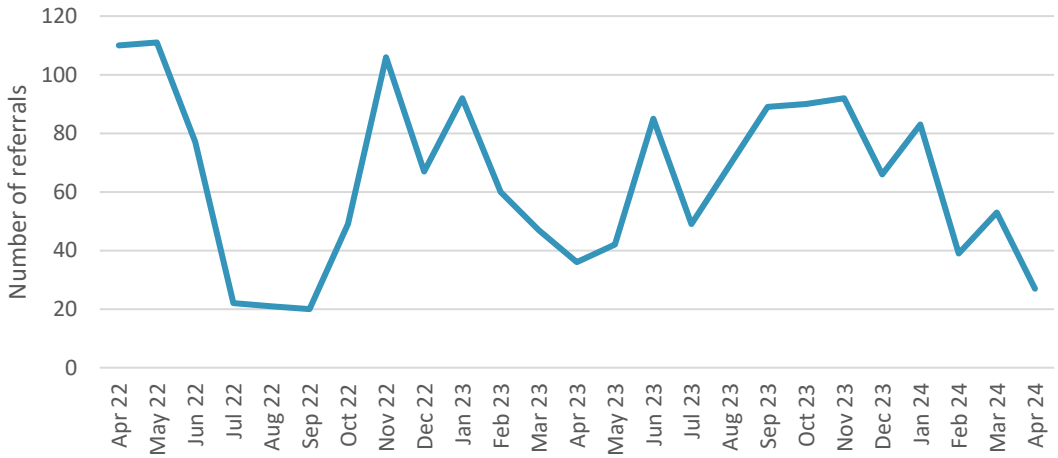
> *"Sometimes it can be ED to SP [and then] into Safe Haven and they'll do the last appointment closed and they've referred into us or it could be that I know we have had one, you know, maybe about a month ago where [there was] quite complex needs and presenting issues and so they refer to us. We saw them and then the SP worker was going to see them for another occasion because they had some follow up work that they wanted to do and they wanted to make sure that I've done this for you...you know I've done that referral. Let's wrap up that piece of work. Let's look at where you are and what I've been helping you with and then hand you over…You know, we're linking closely with those handovers of making sure that we've got all the information and where those young people are and what their support needs are." (WS4)*

3.2 Who is accessing the Navigator programme? (Reach)

Referrals

The total number of recorded referrals from 1st April 2022 to 11th April 2024 received across all five sites was 1,602[15]. The number of referrals by month and year are presented in Figure 2. The highest number of referrals were in Portsmouth (n=313) and Southampton (n=293), followed by Basingstoke (n=76), and Winchester (n=70), with fewer total referrals during the period in Isle of Wight (n=14). Of the remaining, there were 174 referrals made from an ED (location unknown) directly to the social prescribing 111 service[16], 17 referrals had ED listed but no precise location, and information on location was missing for 645 referrals[17].

Figure 2: Number of referrals by month and year, all hospital sites



[15] The dataset included an additional 631 cases, however 121 of these cases were referrals which had been received prior to the commencement of the current programme commission. They remained as case records because the CYP had accessed the service since the original referral date. For the remaining 510 cases the referral date was missing, thus it was not possible to confirm that they were cases referred in the current commission and so have also been excluded from the current analysis.

[16] The SP 111 service is currently funded by the ICB not by the current Hampshire and Isle of Wight VRU commission.

[17] Changes have been made recently to data capture to ensure location is now being recorded accurately.

Demographics and other factors

Of all referrals, the majority identified as female (68.0%; n=832), three in ten identified as male (27.4%; n=335), and 4.7% (n=57) identified as non-binary, transsexual, or other. Gender identity was missing for 378 individuals. A small proportion of individuals (0.5%; n=8) were >11 years old, 44.9% (n=720) were 11-15 years, 32.6% (n=522) were 16-18 years, and 22.0% (n=352) were 19+ years. The majority of individuals identified as White ethnicity (84.1%; n=916), 4.1% (n=44) identified as mixed or multiple ethnicity, 2.9% (n=32) as Asian or Asian British, 1.4% (n=15) as Black or Black British, and 1.0% (n=11) as another ethnicity. Data on ethnicity was missing for 598 individuals. Nearly half (45.6%; n=428) of individuals were straight, 21.1% (n=198) were LGBTQIA+, whilst 33.3% (n=313) preferred not to say or were unsure. Sexuality was missing for 663 individuals.

Individuals' neurodiversity, learning needs, long-term conditions and physical disabilities are also captured. 4.8% (n=68) of individuals were recorded as having ADHD, 3.3% (n=46) were neurodivergent, 3.7% (n=60) had educational or behavioural difficulties, 4.1% (n=65) had learning difficulties, 3.2% (n=51) had a long-term illness, 2.0% (n=32) had a physical disability, and 0.7% (n=11) had a sensory impairment.

Identified risks

Risk factors and issues identified for support are assessed on an ongoing basis as the Navigator works with each young person. The analysis of the data showed that over half (53.6%; n=858) had risks related to emotional wellbeing, 6.2% (n=99) related to personal safety, 5.2% (n=84) related to substance use, 1.9% (n=30) risks related to housing circumstances, 1.7% (n=28) related to physical or sexual health concerns, 0.9% (n=15) related to parenting or relationships, 0.9% (n=14) criminal or legal issues, 0.9% (n=14) related to training or study issues, 0.5% (n=8) related to personal development, and 0.2% (n=3) related to income or benefits.

3.3 What are CYP receiving? (delivery and dose)

Findings from the monitoring data showed that of the 1,602 referrals during the period April 2022 to April 2024, a total of 10,323 individual actions of support were recorded by the Youth Workers. The average (mean) number of actions per case was six and ranged from one to 94 actions. The average (mean) time spent on each action was 16 minutes but ranged in time from less than one minute up to four hours. The largest number of actions were categorised as support (48.7%; n=5,028), with the next largest actions related to admin tasks (33.1%; n=3,418). 508 actions (4.9%) involved some type of assessment. The remaining 1,369 (13.3%) actions related to appointments with the young person or their family. The majority of actions related directly to the young person (72.6%; n=7,490), whilst 14.3% (n=1,480) were with a family member, friend or another person, and 13.1% (n=1,353) of actions involved work with other professionals. The majority of actions (66.5%) were undertaken via text message (34.9%; n=3,600), phone call (25.7%; n=2,655) or leaving a voice message (5.9%; n=612). 16.5% (n=1,708) of actions were completed face-to-face, whilst 10.0% (n=1,037) were via email, 5.3% (n=552) via letter, and less than 2.0% were completed via video chat (0.7%; n=72), web form (0.5%; n=47) and online chat (0.1%; n=9). The method of interaction was not specified for 0.3% (n=31) actions.

Youth Workers provide support to CYP in the ED only or may refer them to the SP programme for further support. Of all actions recorded for the period, the majority (93.7%; n=9,674) were related to CYP being supported by the SP team.

For each action which is recorded, several 'events' may be attached to this action. Events refer to the specific CYP needs which are aiming to be addressed through a given action. Given each young person

may have multiple actions recorded, and multiple events for each action, at this stage it is not feasible to perform a quantitative analysis of events however the categories of events recorded for which actions were conducted included: emotional wellbeing, service information, relationships, school, training or studying, physical health, substance use, neglect, violence or exploitation, work, bullying, discrimination or crime, housing, personal development, sexual health, income, benefits or tax, security, stability or being cared for, antisocial behaviour, parenting, budgeting and community participation.

Holistic person-centred support

Stakeholders highlighted that many of the individuals with whom they engage have not necessarily experienced violence but present with other vulnerabilities, the most common of which is mental health. The focus of support is holistic and tailored to the individual and can be around a number of different aspects, for example, mental health i.e., overdose, victims of assault, self-harm and suicide and bereavement, struggling with socialising, drug and substance use, LGBTQ+, eating disorders, counselling, access to safe havens, advocating for CYP where bullying is happening in the school setting, providing family support and helping to build up relationships etc. The support can also be more practical, providing clothes and toiletries (e.g., sanitary products, deodorants, toothbrushes etc.).

> *"All the young people I've seen so far, there's not really been any relation to crime unless they've been obviously coming in on different days… I would say the people that I've seen in the ED so far, they've all just been related to mental health. There's not really been any concern as of yet, but that's something, you know, I'm hoping that we'll sort of open up a little bit more." (N3)*

One stakeholder spoke about commonly seeing CYP aged 13-16 years presenting at the ED and that this age group in particular is impacted by social media. It was felt that CYP are not aware of the impact of their behaviours on social media with some platforms allowing users to join under anonymous accounts; these individuals are then targeting people with upsetting content within chats, which are then deleted (unless saved), so there is no evidence to fall back on. This was seen to create 'turmoil' with some CYP experiencing a 'constant barrage' of messages.

> *"…a huge thing I'm finding with young people, is social media… that's the one thing that's very common and find it with young people is that they'd have access to something like Snapchat or, you know, TikTok or really any sort of social media platform, anything that they can talk to their mates with. I'm finding that that seems to be the big issue where especially Snapchat for example. Where the chats are anonymous and they get deleted." (N3)*

From October 2024, No Limits began to deliver an offer through the MHST. Whilst this team is only currently available in Southampton, this was seen to provide another protective avenue of support. It is available for those with trauma-led issues (e.g., when they turn 18 and are moving from CAMHS to Adult Social Care, or College to University, or care system leavers), and aims to offer advocacy, practical solutions focussed support including signposting.

> *"I can give it straight to [name] or [name] and say I think this person is perfect for some sort of SP or [No Limits] have got a new mental health transition team and… of the people that I've seen so far and I haven't seen many have been in that mental health transition where they've had chaotic life, they've got some trauma lead issues and their mental health isn't brilliant...They're 18, so they [the*

*Youth Workers] are stopping them falling through the cracks…So I think this mental health team is very new, but I think it's going to be an area of growth [as well as moving from CAMHS to adult social care]…it's also about moving from school to sixth from college and needing some advocacy or from sixth form college into university and leaving home or even people in the care system leaving the care system and transitioning into independence. They've got there and it and everything's gone **** **…this is a transition that we're not quite [there] yet, so you might just give four sessions of that social prescribing through the mental health transitions team." (N9)*

Below are a number of case studies that provide examples of the complexity of the contextual vulnerabilities that individuals present with at the ED and when engaging with the Youth Workers. There are also further case studies, which can be found in Appendix 2.

Presenting condition/situation on presentation: YP was admitted to Basingstoke Hospital following a suicide attempt and severe self-harm. Youth Worker received a consent to contact and began working with YP in a social prescribing capacity a few weeks later.

Contextual vulnerabilities:

- Suicide attempt
- Suicidal ideation
- Drug use
- Victim of drug grooming

Female – aged 16

Source: No Limits secondary

Engagement with the Youth Worker (YW): YW and YP met for first social prescribing appointment and completed a Progress Wheel and a 'What to Know About Me' work sheet. This gave an idea about what the presenting factors were and anything else to be aware of. YP shared that they have a difficult relationship with their father due to his drug habits, and that Mum and Dad have an 'on off' very toxic relationship. The YW initially worked on this with the YP who was also under a child in need plan, with social workers involved due to her dad dealing drugs. After approximately 3 months of working together, the YP confided in the YW that they were involved in an ongoing police investigation as she has been used, by her Dad, to run drugs and test out new drugs from the age of about 14. After exploring the involvement it was possible for the YW to have, it was apparent that the YW could continue working with YP, but that it was necessary to make sure that they were only offering a listening ear as well as checking on the YPs emotional well-being. The investigation lasted around four months. Over this time, the YW supported the YP in a variety of ways, including visiting the courtroom with them prior to giving their witness statements, as well as referring the YP to more specialised support such as Aurora and Victim Support Hampshire.

After the Police investigation was completed, the YP and her family moved out of the country for a fresh start with the YP contacting the YW to let them know that they were settled and doing well.

''[YW] I am so thankful for all your time and patience, you have had such a positive impact on my life, and saw me through a really difficult time, you are amazing!''(YP)

''[YP name] is so fond of you, you have done more for them and the whole family than you probably realise, we can't say thank you enough.'' (Mum)

"You [YW] have been a fantastic presence thought the investigation and beforehand, I will definitely be recommending your service in the future.' (Social Worker)

Presenting condition/situation on presentation: YP is a frequent attender at the ED and has been for some time. YP regularly attends for self-harm, overdose and requires medical treatment for self-harm. When YP attends, the YW often offer support to talk about feelings and recent things that may have happened to try and build a relationship.

The current care plan was to not give YP stitches as she will remove these herself and the wound would not heal. The YP now receives staples for her self-harm but then has to come back to ED to get these removed. This was not working for YP as she shared that she felt if she was going to the ED then she 'might as well self-harm'.

Contextual vulnerabilities:

- Self-harm
- Intentional overdose
- Historic trauma
- Young carer

Female – aged 21

Source: No Limits secondary

Engagement with the Youth Worker (YW): During a conversation with the YP, YW suggested ways to support her alongside the current care plan. The YP explained that she sometimes comes to ED to get gratification from the hospital staff there. It gives YP pleasure if the staff at the hospital see her self-harm and react shocked. Equally, if the staff at the hospital comment that her cuts are 'not too bad' or 'in a safe place' then the YP will make it worse or cut in a more dangerous place next time. YP explained that even facial expressions and body language gave her either satisfaction or disappointment from viewing her self-harm. YP also felt that if she was coming to ED then she 'might as well make it worth it' and would self-harm before arriving. With this information, the YW suggested that they create a safety plan together to advise doctors, nurses and other professionals to remain neutral when giving YP medical treatment. The safety plan also said that YP will get her staples removed by her GP, rather than coming back to ED. This was discussed with a doctor and was signed off.

The safety plan was uploaded to the hospital patient system and the YPs medical records, so that is available to everyone who treats the YP. The YP can also ask professionals to look it up if they haven't seen it, empowering the YP to ask for the support she needs in that moment. The aim of this was to reduce YPs attendance in the emergency department and the YP had not reattended ED since this engagement with No Limits.

Presenting condition/situation on presentation: YP had been sofa surfing for the past 2 months as she was unable to live at home as her Mum was struggling with her own mental health and the YP had no support network. There had been a family bereavement of the person who the YP usually confided in. Mum was occasionally allowing the YP to sleep on the sofa but was due to move area and was also supporting another family member temporarily. YP stated they had been to get housing support but was not able to get anything in place regarding their accommodation. They were in a relationship and occasionally stayed with her partners family at weekends but was unable to stay there permanently. The YP's mental health had declined drastically leading them to feel suicidal and they called NHS 111.

Contextual vulnerabilities:

- Mental health
- Street homeless
- Suicidal ideation
- History of overdose
- Possible ADHD/ASC

Female – aged 19

Source: No Limits secondary

Engagement with the Youth Worker (YW): The YW worked with the YP over a 4-month period. Together, they contacted council housing, 'The Foyer' (accommodation for people aged 18-25 experiencing homelessness), and local estate agents to try and source some permanent housing options and the YP was subsequently added to the council housing waitlist and on an urgent waitlist with 'The Foyer' and local agents. The YW also liaised with the YPs Mum to see what family support could be put in place and the YPs Mum agreed to allow her to stay at home when needed up until December when they were moving. YW encouraged the YP to consider counselling for the family bereavement as well as looking at other ways they could support to improve their mental health. The YW provided the YP with useful apps and websites around ASC and ADHD as the YP felt that she was neurodivergent and the YW supported the YP to speak to her GP to make a referral for assessment. The YW supported the YP to seek work opportunities to give her a stable income and also helped her to apply for PIP. This enabled the YP to seek out most opportunities herself.

At the end of the social prescribing support, the YP was successfully in her own rented flat, had started work as a carer and was also in full receipt of PIP. The relationship with her Mum was improving as a result of the new stability in the YPs life and the YP stated that her mental health was improving as she felt she had a purpose now and no longer felt suicidal. The YP was able to look positively towards the future again, looking to share a property with her partner and increasing her hours at work.

"I cannot thank you enough. I have a place of my own and [I'm] earning my own money. Things with Mum are better and it's nice that I can make my own decisions, and my relationship is going well too. I am in a much better place."

(YP)

Presenting condition/situation on presentation: YP attended ED a week before his birthday after self-harming and needing stitches. YP temporarily lived with his sister after having a bad relationship with his father and being kicked out. YP said he had a hard childhood with the Police always at his house because of his family and parents arguing. YP explained he did not trust anyone and had bad anxiety about leaving the house - YP did not go anywhere alone. YP loved makeup but only used it when he was happy so said he had not put on makeup in a long time. In the ED, the YP was signposted to talking therapies, Kooth, harmless, Solent Mind and Safe Havens and placed on the No Limits waitlist to explore additional support when he was out of ED and more willing to engage in support.

Contextual vulnerabilities:

- **Self-harm**
- **Anxiety**
- **Homelessness**
- **Sexuality struggles**

Male – aged 19

Source: No Limits secondary

Engagement with the Youth Worker (YW): When social prescribing began, the YP was sofa surfing between family and friends. YP's mental health was very low with his anxiety at its worst. The YW took the YP to the Portsmouth Civic office to present him as homeless where he was then given an Independent Supported Housing Assessor in Young Persons Services. YP attended housing appointments with the YW providing support and advocating for the YP. The YP was placed on a waiting list for 'The Foyer'. During SP appointments, the YW helped the YP to search online for suitable and safe accommodation and attended a viewing together. YP also started taking his anti-depressants and engaging with talking therapies. The YW booked a final viewing for a property for the YP, who said he felt confident enough to take his dad with him which was a huge step forward.

The YP successfully viewed and secured a room in the shared house with his housing benefits. The YP shared that his dad had commented how proud he was of the YP, which was a great start to rebuilding a fractured relationship. The YP is no longer homeless and was referred to Solent Mind for support around his anxiety and mental health. The YP shared that he is now wearing makeup again and feels very proud of himself.

Direct Youth Worker support – four session social prescribing model

Discussion focussed upon the number of sessions of support that CYP are able to access, how this was perceived to have changed over the duration of the programme implementation, and the impacts of this.

Those who engage with the SP programme are typically offered around four sessions of support from a Youth Worker. Increases in engagement have not been due to procedural change, but instead due to the needs of the CYP, resulting in an average of around six to eight sessions. Some were extended beyond this where there were safeguarding concerns[18] of complex needs with no other organisations available to take the young person on for support.

One stakeholder commented that at the programme's inception, there were not such 'tight restrictions' on the number of community-based appointments the Youth Workers had with individuals. It was acknowledged, that there should be flexibility in the approach, acknowledging that some individuals may only need one or two sessions, however, that there are those that may 'need a little bit longer' due to the presenting nature of their issues and the severity of their case, and 'how they cope with change'. The length of engagement may also be impacted where a young person has 'already got those kind of connections' to services.

> *"There's so much to unpick…if we then have the four appointments by the time you've got to appointment four, they've then disclosed something else to you, which is a whole other thing that you need to unpick…" (N4)*

> *"…there should be some sort of flexibility in the same way as there would be…for a counselling service where it might be six sessions but it might take a bit longer than that…It's all about relationships at the end of the day, isn't it… how quickly they can make kind of the relationships with young people and we talk about that kind of reachable moment… those young people are in a vulnerable position, aren't they in terms of being at the hospital..." (N7)*

It was commented by one stakeholder that the number of SP Youth Worker sessions may also differ by hospital where ED/SP activity may be lower, and it is therefore possible to provide a greater degree of flexibility around the number of sessions, i.e. facilitate more than four sessions.

> *"…Southampton is a huge city…There is so much more going on there where there's so much more need…There's still a need [on the Isle of Wight], but it's not as prominent as a main city…So it's really tailored into what we can work with the young people" (N3)*

Where individuals are based on a ward, this may include long-stays (e.g., for those with eating disorders) and therefore support is provided until they are discharged and then the SP element may be continued in the community.

> *"…we build up quite a rapport with those young people and really support them on their journey while they're in hospital. Some of them are discharged home. Some of them are discharged to say Tier 4 specialist beds. So depending on where they're at, we work alongside them and the professionals and help with those*

[18] Safeguarding issues (serious incidents) identified through quarterly reports include: Emotional wellbeing, Personal Safety, Crime and Legal issues, and Substance Use.

relationships. We then also have the young people that come in through the emergency department or are there for a few hours and then go home…" (N4)

It was highlighted that from Quarter 4 of 2023/24, the SP model now follows a defined four sessions model. This was implemented after looking at the waiting list management and making the use of the progress review mandatory, and evidence suggesting that when using routine outcome monitoring effectively (including goal-based outcomes), CYP may not need as many sessions. It was commented by one stakeholder that having four sessions means the SP support is more 'structured' and 'intense' in a way that is better for the individual and may lead to less reliance upon the programme. Also, that this structure has positively impacted upon Youth Workers making them feel 'much calmer'.

"The boundaries are in place, they know what they're getting and there's the four sessions, they make their appointments, then the referrals go in, and then off they go. And then they know where they can go obviously if they need to, you know, if they want to receive further support." (N8)

"...there should be a minimum like we've got that they have contact, but then absolutely it should be around sort of what the needs of that individual all whilst recognising as well that some people become very dependent on services. So we also have to sort of allay those expectations that although you might want us here for the rest of your life [this is a short-term intervention]." (N6)

It was discussed that the duration (e.g., 10 minutes to an hour or more) and frequency (e.g., once a week, once a month, every couple of months) of these SP sessions can vary from individual-to-individual dependent upon need; as can the way in which the engagement takes place - face-to-face (e.g., meeting for a coffee or a walk or attending an activity with them), over the telephone, text (e.g., for 'quick check-ins' or 'making an appointment'), e-mail, online. This is dependent upon 'what is best for the young person' and therefore, the programme 'tailors to them'. The importance of accessibility of the service was highlighted by a number of stakeholders.

"…phone calls are quite easy for them because it's, you know, it's not a face that they're having to speak to, but on the other side of things, the face to face helps them sort of engage a bit more…a lot of the time it really is tailoring to how they just, you know, they prefer the communication." (N3)

"…the brilliance of the SP is that 'Where do you live? I'll come see you there. Let's go to cafe. Let's go to school.' You know, and I think that works brilliantly for young people to meet them exactly where they are to make it less anxiety provoking to make it…in Southampton we have got CAMHS over on one side of Southampton…if you're on the east side, you've got to travel all the way across at a cost, at a stress, at a pressure. And the beauty of the SP is that like, let's meet you where you are or I can take you to the doctor. I can take you to the gym. I can, you know, all that stuff." (WS4)

3.4 Outputs and outcomes

Outputs

Outputs collected through the No Limits (ED/SP/111) Navigator programme include:

- Number and demographics of CYP referred/contacted.

- Number and demographics of CYP engaged in interventions (through No Limits Social Prescribing Service).
- Number and demographics of CYP taking up and attending referrals/interventions (external to No Limits services, i.e. other agencies).
- Numbers and demographics of CYP engaged by event categories/presenting issues, e.g., eating/body image, Emotional Based School Avoidance (EBSA), domestic abuse, drug/substance related harm, isolation/loneliness.
- Patient qualitative and quantitative feedback and case studies – including qualitative feedback from hospital staff and family/parent/carers.
- Any additional programme monitoring data. For example, referral access point, reasons for non-engagement etc.

Each quarter, No Limits provided a written report which reflects upon key data relating to key aspects of the (ED/SP/111) Navigator programme. The quarterly reports include:

- ED data including key presenting issues, details around the age and gender of those presenting.
- Challenges with delivery.
- Feedback from CYP and their parents/carers and feedback from professionals – No Limits have a feedback form designed for the service, which is available in QR code form on posters in all hospital sites and on cards that the Youth Workers have when working with CYP. This enables CYP to reflect on their initial engagement, which may be something that is difficult to bring into conversation at the initial meeting. Feedback can also be given via paper forms or links that can be text or emailed. Youth Workers also gather verbal feedback and quotes which are held on a central document. The feedback received via the feedback form is held by the Service Manager and used for reflection and to inform any challenge/concerns/changes to the service and shared anonymously with the team.
- Details around supervision.
- Identified safeguarding issues, e.g., personal safety, emotional wellbeing, crime and legal issues, personal development and participation (difficulty managing behaviour).
- Training undertaken by No Limits staff.
- Information relating to the outcomes measures as evidenced through the Simple Mental Health Pain Scale and the Progress Review.
- Case studies.

Outcomes

Findings from the monitoring data showed that of 118 cases which had pre and post data on the Simple Mental Health Pain Scale, there was a statistically significant decrease in mean score from pre to post assessment (pre, 7.18; post, 4.78; $p<0.001$) indicating a positive change.

There were a number of positive outcomes that were identified through the interviews that reflect change on an individual, family/community, and system level.

> *"…better outcomes for young people, transitions into different services, [the] youth work element, empowerment, participation, better quality of life. But also hopes and dreams as well. I'm always a person to be like, if one person believes in you, you can do anything. And I think once a young person engages with No Limits, they will engage with us until their 26th birthday and they will tap in and out…to the service but also be fluid with the needs of a young person. They could lose their job like normal stuff that happens day-to-day. But you know with young*

people they have the lowest benefit. They have no support networks, you know, and actually it's about that early intervention before it becomes a long-term issue…" WS6)

Individual

The Youth Workers were seen by stakeholders to provide early intervention for CYP. They **build relationships and establish trust** with the CYP that help them to feel supported in being able to speak about things they may not have discussed before. This may lead to an **increase in first disclosures** (e.g., around historic sexual abuse, domestic violence, honour-based violence, isolation, issues at school) including safeguarding disclosures, but this was viewed as a positive outcome of the programme as *"it just shows how successful it is" (N8).* The Youth Workers advocate for individuals, providing them with a 'voice' and helping them to foster relationships with other professionals and services who may be able to provide them with support. One example includes two CYP who were supported in relation to being victims of domestic violence. The Youth Worker was able to build rapport, support and connect the CYP to the STAR project and the You Trust to achieve positive life changes where they can now look towards a brighter future away from harm.

"The way I see it is if we can get them support now that it's early on in their lifetime of mental health issues. If we can get it in the right place early on when they're in this sort of transition stage, isn't it from child to adult…as they develop, I think it's really important. And if we can get them, if someone who talks to them and understands them, I think it's fantastic." (WS1)

"You saved my life, you really did and mum knows that too, you have kept me going, thank you so much for everything." (Young person, secondary data)

"…sitting in a meeting, and it's like Consultants and the Head of Safeguarding…our voice is sometimes the loudest in those rooms because with the voice of the young person who either isn't sitting in that room or doesn't feel brave enough to talk… we make sure that those young people have got their voice heard in those big rooms." (N4)

"[Youth Worker] was so supportive and understanding. I never felt judged for what I said and it felt like I was talking to a friend." (Young person, secondary data)

Establishing these relationships and helping individuals to access support was also seen to help them to **feel less isolated by helping them to become integrated into community-based activities.** It was commented by one stakeholder that post-COVID, *"young people really struggle with community-based things with sort of making friends with integrating and definitely with things like being able to navigate themselves around a friendship" (N1).* It also helps individuals to **feel empowered** as they are able to **make informed decisions** (e.g., to have some control in their vulnerability and medical choices and consent within their care, through being introduced to different strategies around negotiating relationships and navigating 'everyday life', being provided with information they did not previously have, knowing that they can access support away from the ED/ward etc.).

"It's nice to have a space where you can give insight into how other people might feel or act and don't just always tell me what I need to hear. Sometimes I need to be told, in a nice way of course how my behavior can change a situation. But then you're so nice and actually explain why I might behave like that. My trauma does

change how I act and it's nice to know now that it isn't my fault." (Young person feedback provided in Q2 2023/24 quarterly report)

"I was feeling really broken when I came into the hospital but [Youth Worker] really listened to me and got to know me. She sat on the floor with me and spoke to me like a human. She helped me fill out a form to get support for drugs." (Young person, secondary data)

This helps to **increase their resilience and self-esteem** and provide an overall sense of **improved wellbeing** (including increased confidence)**,** which will then impact not only upon the individual's life choices and pathway (e.g., education and training, employment) but the wider system.

"…[the Youth Workers] support young people engaging in the support, schools and employment. So they could be pointed in the right direction as to, you know, getting the job, college, apprenticeships and hopefully they have improved emotional wellbeing because they'll have that they have that support in place. They increase in self-confidence and self-esteem and emotional resilience." (N8)

"[Youth Worker] is worth her weight in gold. The improvement I have seen in my daughter and her ability to manage her emotions and communicate her needs is something I am so grateful for [Youth Worker's] support and compassion…After her last appointment she told me 'Mum, I want to be like [Youth Worker] when I am older.' This is the same child who did not see herself growing up or attending prom because she was intent on ending her life. [Youth Worker] does not realise that she has given my daughter a future by simply taking time and being nothing but herself." (Parent, secondary data)

"I would also like to say thank you for all that you have helped me with and just for being there for me and listening! You have honestly been a wonderful practitioner who always makes me feel cared for and safe." (Young person feedback provided in Q3 2023/24 quarterly report).

"Thank you for all the support you've given me. Before meeting you, I struggled with my self-confidence, but you helped me learn to love and value myself, and to take each day as it comes. I'm now surrounded by friends who appreciate and value me." (Young person, secondary data)

Specific examples of outcomes related to physical and mental health were detailed. For example, in the quarterly No Limits reporting, this included: CYP having had a significant reduction in self-harming. Children and young people with eating disorders beginning to enjoy hobbies and socialising again, with an overall increase in emotional resilience and many now have a higher awareness of their own mental health difficulties, anxieties, and triggers. It was also reported that some young people had stopped using drugs and alcohol, or for example, started taking their medication more regularly etc.

"A YP on the final session of social prescribing shared the significant progress she had made. YP used to take at least 3.5 grams of weed weekly but shared that she had stopped using weed and it has been almost three months now. She testified that the support from different partners is making a difference in her life and is committed to live a better life." (ED/SP/111, secondary data)

"I get the pleasure of hearing the success stories from current and previous young people I have worked with. One in particular that has really stood out to me is a YP that I supported through a police investigation as a victim of drug grooming. YP came to me at a very low point – high levels of self-harm and numerous attempt to take their life. I received a photo from the YP a few weeks ago of them in Paris, they have moved there with their mum to study law at university, they are enjoying their new life and have been clean from self-harm for 11 months, I definitely had a tear in my eye hearing from her." (ED/SP/111, secondary data)

Stakeholders commented that improvements at school may be a possible outcome, with information relayed to Youth Workers through self-reporting from parents of CYP engaged with SP programme. No Limits monitoring data also detailed how CYP with EBSA have increased their school attendance.

"…we'll know from talking to parents, if we're in contact with parents, whether sort of school's got better..." (N1)

Family / Community

As a result of engaging with the Youth Workers, individuals were seen to **build positive relationships with family (e.g., parents) and friends (e.g., at school)**. It was highlighted that this is also a result of the Youth Workers working with the family as part of the support that they provide to individuals.

"We see positive improvements with relationships within the family because wherever possible, we will work with the wider family, not just the young person, because systemically it is we all know that it's best to work with everybody within the young person's life wherever possible." (N1)

"Cannot thank you enough. I now have a place of my own and earning my own money, things with Mum are better and it's nice that I can make my own decisions." (Young person feedback provided in Q3 2024/25 quarterly report).

The ED/SP Programme was seen by all stakeholders to meet families at a point of crisis and provide parents with some comfort in that they know their child was now receiving support, for example, where there may have been frustrations around CYP having long waits to access any kind of support. This was also seen to help prevent issues escalating further with CYP then re-presenting at the ED.

"You have done so much for our family, you came at the lowest point with a big smile and positivity that was infectious, thank you from the bottom of our heart for all that you have done.'' (Parent/family, secondary data)

"They're meeting a lot of families that are sort of at their wits end and they're really that great intervention to try and go right. Let me make this referral. Let me talk to CAMHS. Let me do this. Let me do that. Whatever I can do to try and get you into a right service, it's going to really help. You know you're 18 weeks for assessment with CAMHS. You've long waits in between appointments, you know, waiting lists are massive… [No Limits] definitely help those young people that are in between appointments are waiting to be seen by specialised services." (WS4)

"[Youth Worker] gave me support and practical advice for my son and even recommended a book which I have purchased and have been implementing. I am so grateful. She also encouraged me saying I am doing lots of good strategies with my son." (Parent/family, secondary data)

System

The programme hopes to **reduce readmissions to the ED** and stakeholders based both within the hospitals and No Limits services commented that it helps with the 'strain' that hospitals are under. It was felt that once an individual is discharged from the ED and working with the Youth Worker on the SP element, the extra support helps the individual *"feel that [they didn't] need to go back into the ED" (N1)* as they have community support. This was also linked to a **reduction in the number of individuals self-harming**. **Violence reduction** was seen by some of the stakeholders as a longer-term aim.

> *"I know that we've recorded how many readmissions we get within our hospitals and the number significantly decreases when they've had that community support with us. They won't present in the hospital whilst they've got that support and they're speaking to us. But then if they don't have that support, we can see them numerous times keep popping up." (N4)*

> *"I think they [the No Limits ED/SP Teams] have a massive impact. I think the feedback from the hospitals is it really helps with the strain and what they're trying to deal with and being able to hand that over…I suppose in terms of the violence reduction, it's going to be a long-term impact. You would say like can we see ahead that we're seeing changes?" (WS4)*

Stakeholders within No Limits and the hospitals discussed that there can be a high intensity of repeat people (e.g., the ED might see the same person five times in one week). It was suggested that with the No Limits ED/SP Programme, there may have been a small decrease in recurrent attenders, but that it is important to acknowledge that many of these CYP have experienced childhood trauma and are mistrusting of services and that it takes building trust and rapport to get them to engage.

> *"You've gotta look at what's causing that mental health. 9 times out of 10, it's coming from childhood trauma. So that impacts on their mental health and then how they cope with that mental health is substance misuse. So then you're in that vicious circle of what services can [do to] support those people. And actually, we're really thankful to have No Limits because soon as they hit a certain age, there's limited support for them when their substance misuse is involved. But we also work with our psych liaison team as well…We all work together." (WS2)*

It was identified that the Youth Workers are 'linked up' and skilled in **making connections and developing relationships with other professionals** – acknowledging that there were challenges initially - and that this was not only a benefit when signposting individuals/making referrals, but that professionals value the Youth Workers and the impact they have upon the treatment outcomes of individuals as well as their experience of being in hospital.

> *"Early days we had a bit of a challenge of trying to get them [the Youth Workers] integrated within the AMH (adult mental health) liaison service and I think they've done some really good work in terms of building those kind of links." (N7)*

> *"How do you do it? You connect with these young people in such a magical way. Many of these outbursts have resulted in violence and staff getting hurt and needing to call security but you were able to deescalate so calmly and easily and protect so many others in the process. Thank you so much for all that you do. You're a godsend to our patients." (Professional feedback provided in Q3 2023/24 quarterly report)*

"Incredible joint work in Southampton ED, the YP is very vulnerable, has a lot of complexities and huge distrust in the hospital and professionals in general. You made her feel at ease and comfortable from the moment she came into the hospital, this absolutely made my job easier coming in and I believe the outcome would have been completely different if you weren't there, without the support from yourself, especially being there to advocate for [name of CYP] during interactions with nurses and providing a non-judgemental face had such a positive impact on the outcome for YP. Thank you so much!" (Professional, secondary data)

Within this it was also identified that the No Limits Youth Workers have worked in partnership with Youth Workers from other parts of the country who know about the programme and have sought help – an example was given around a Youth Worker from Leeds who was in contact because one of their clients was admitted to Southampton Hospital.

"A Youth Worker from a Leeds Hospital has been in contact with us to say that one of their young people has been admitted to Southampton and they know that we've got Youth Workers to come and go and see them...and that's great because they obviously know that we've got a project down here as well." (N2)

Increased knowledge and awareness were seen to be a positive outcome for the Youth Workers that was achieved through training (e.g., crisis management, challenging behaviour training, suicide awareness and suicidal ideation)[19] relevant to their role. Sharing of skills and resources between Youth Workers was seen to be important, with team meetings being used as a forum through which this may take place. The Youth Workers are seen to communicate well with each other, for example, seeking advice from each other and providing peer support.

"We do skill sharing sessions as well within our team meetings…So anything that somebody's used recently, if they've read an article, if they found a new app, it's shared within the team. We also share how you've used that and how it's worked…So it's a really good opportunity to just to share what else we found." (N1)

[19] All No Limits staff are fully inducted and complete identified mandatory and role specific training. No Limits deliver in house training on a rolling programme. All staff attend Safeguarding L2 and attend L3 when available. Specific training cited in No Limits monitoring data includes: Alcohol Awareness and Support; An introduction to having honest conversations (HSCP); Anxiety and Anxiety relating to war and conflict; Autism and ADHD; BEAT – Support for Eating Disorders During the Festive Period; Benefits; Beyond the Headlines – Childhood Wellbeing in a Changing World; Changing the narrative around suicide; Connect 5 Mental Health Training; Cyber Security Awareness; CYP and Benefits and Housing Rights; CYPMHC – Challenging Islamophobia in Clinical Practice; DEI Training; Disability Rights; Domestic abuse; Eating Disorder 1 day training – Charlie Waller Trust; EBSA and Exam Stress; Emotional Resilience; Exploitation; Health and Attendance Management (SM/PM); Healthy Relationships; Homelessness and Temporary Accommodation; Introduction to AMPARO support following suicide service; Introduction to Eligibility for Housing Assistance; Level 5 Safeguarding for Managers; Mental Health First Aid; MIND – Connect 5, Neurodiversity training for those working with YP ; The Brain Charity; NHS Solent 'The Challenges of Gender Transition' Webinar; NHS Solent Chemsex Webinar; NL Database Champion Training x2; OCD awareness training; Perinatal Mental Health; PPN – Psychologically Informed Crisis Care; PREVENT; Safeguarding Adult Reviews – Learning from practice (PM); Self-care and workplace wellness (SM); Sexual Health and Relationships; Sexual Health sign off (able to issue GIO services); Southampton Alcohol Misuse Awareness; Substance Use; and Virtual Crisis Training – Anna Freud.

"…we regularly have team meetings and the team are constantly seeking advice from each other. And I think even just encouraging that, there's like constant peer support…they'll all support each other because it might have been something that they've dealt with before, particularly if it's something that we don't come across quite often. They're always sort of sharing resources with each other and supporting each other." (N2)

"There's lots of training as well and the quality of training that I've received has been excellent." (N9)

Monitoring of programme implementation and outcomes

It was commented by stakeholders that it was difficult to measure longer-term impacts of the programme because of the nature of the programme, but that shorter-term outcomes can be evidenced through monitoring reports, case studies, and feedback from those who have engaged with the programme.

Initially at the programme's inception, there was consideration of using WEMWBS and SWEMWBS to monitor mental wellbeing outcomes, however, anecdotal evidence from Youth Workers suggested that CYP did not like completing this measure and Youth Workers perceived the collecting of this data as a barrier to building a trusted relationship with the young person. Following a service review of the outcome measures which could be collected, the decision was made to use the Simple Mental Pain Scale and the Progress Wheel. Both measures are taken pre and post support so that it is possible to see areas where change and improvement has been made.

For the purposes of the current evaluation, individual data for the period April 2022-April 2024 was provided to determine the dose and reach of the programme (including demographic data and other factors), levels of engagement, extent and nature of support provided, and impact of the programme. To inform recommendations on future data monitoring, an assessment of the quality of the dataset was undertaken using four metrics: completeness, validity, consistency, and integrity.

- *Completeness.* Completeness refers to whether all required information is in the dataset. Overall, many fields were missing. However, the recording process is that only CYP who are case held by SP have a case record completed for them. This means that for CYP who only have contact with the Youth Worker in the ED there is less information captured on them (basic demographics and reasons for presentation to the service). This makes sense considering the ED teams may only meet a young person briefly on one or two occasions and capturing and recording this information would involve taking time up in these brief interactions which could otherwise be used to deliver the brief intervention. However, this does mean the details on the dose and type of support provided to CYP in ED is not captured. Referral dates were also missing for 510 cases. These cases were excluded from the current analysis because the dataset also included some individuals referred to the service prior to the current commission.
- *Validity.* Data is considered valid if it matches rules specified for it (e.g. format, range etc.). Much of the data used in the current analysis was standardised check boxes so there didn't appear to be an issue regarding validity.
- *Consistency.* Data is considered consistent if it is recorded in the same way by different inputters of the data. Where free text information was used this was at times inconsistent, for example, in the interaction's dataset, there was variation in the interactions' type field with terms session and appointment both being used.

- *Integrity.* When critical linkages between data fields are missing, that data is said to lack integrity. There was a lack of integrity in some instances, particularly around dates of referral, risks, and reasons for presentation to the service.

3.5 Facilitators and barriers

There were several facilitators and barriers to the (ED/SP/111) Navigator programme that were identified, for some of which there is cross-over.

Facilitators

Developing connections

The connections and relationships developed within the hospitals in which the Youth Workers are based and promoting the programme are essential to ensuring that (the correct) referrals are sent through to the programme. It was felt that this was easier to do in some hospitals than others, for example, due to the turnover of staff in hospitals where it has taken time for staff to recognise the Youth Workers and the programme and also that they are not clinicians so cannot be asked for clinical opinions to help diagnose a patient. It was felt that the Youth Workers are embedded within the hospitals more now and that they are adept at ensuring that they are as visible as possible and promoting the programme amongst staff.

> *"Hospitals are extremely busy, changeable places, so you might tell one person what you do, but that person you might not see them again for [a number of months] or they might have been a locum. They might forget, they might tell somebody the wrong information…It's been challenging to get everybody to know what it is that we do. We've been through periods of time where we'll get a consent to contact form for a young person, where it just totally doesn't meet the criteria…it takes time to, I think build up the relationship with the staff within the hospitals for them to remember who we are and what we do…" (N1)*

A multi-agency approach was seen to be key. Stakeholders felt that the relationships that had been developed within the hospitals resulted in better outcomes for individuals, as they do not have to, for example, relay their story multiple times and additional information may be gleaned from partners that can inform the support provided. It was commented that the ED Youth Workers are well integrated within the mental health teams (e.g., CAMHS, VAST), with joint assessments taking place in some instances, or Youth Workers being present as part of meetings to discuss an individual's case.

> *"…our aspiration is that they [the liaison teams and Youth Workers] do a joint assessment to be able to sort of mitigate that person having to tell their story a number of times. However, that isn't always possible because of the time of which that person comes into ED…our psychiatric liaison teams are then able to sort of refer into our ED workers to get that support, so they'll provide that holistic assessment of that young person and understand their social, community needs as well as what other sort of support offer is out there in the community…" (N4)*

> *"I think that multi-agency approach is really the key, isn't it. And you're building up that relationship with the patient from the off when they're in their acute state, you know they're in hospital, they're at their most vulnerable point and that, you know, some are asking for help. So I think the fact that they actually meet those practitioners. I think that's what's good as well." (WS2)*

"They work really closely with our CAMHS department…[but] there are times with CAMHS…they sometimes can't go and see a patient until they're medically fit, whereas No Limits can go in and just speak to a young person. The majority of time they will help us if we're, you know, struggling with a patient that just doesn't want to talk or something they've got that time to go and sit with the patient and talk to them, provide fidget toys, provide you know, therapeutic wellness, talk about their services, you know, talk about how they can help." (WS5)

Example of collaborative working

No Limits work closely with VAST within the Emergency Department at Southampton Hospital (UHS) attending the daily morning briefing with this team to discuss CYP that are currently in ED and in order to share best practice and plan to complete joint assessments.

The Situation: Information was shared between professionals regarding a new gang in Southampton.

What Happened: The lead nurse for VAST shared with the No Limits Lead Youth Worker that there was a new gang in Southampton and that there had been serious sexual assaults upon females. It was also shared that members of the gang were inflicting serious physical injuries, and that whilst there was no specific pattern to victims being targeted, sex workers were at high risk and there was also a risk of HIV.

The No Limits ED team works very closely with other NL projects, particularly with the NL Advice Centre (AC) team and often find that young people who attend the AC, also attend UHS ED and vice versa, so there is a joint approach to creating support plans for CYP.

The information shared from VAST was also shared with the rest of the NL ED team, one of whom had worked at the No Limits AC. They shared their knowledge of this gang from previous discussions, such as many of the assaults were related to drug-related harm and that there had been mention that the main leader had a gun. By networking quickly and effectively, No Limits were then able to share these findings with the VAST team.

These intelligence updates were communicated to the No Limits AC who may be coming into contact with some of the victims or CYP that had knowledge of the gang, with all staff encouraged to submit CPI forms to the police to widen the knowledge of professionals.

No Limits continued to encourage joint working and sharing of information around this concern, by keeping in touch regularly with VAST, ED staff teams and wider No Limits staff and have offered our continued support with joint assessments should any CYP attend ED in relation to this gang and any related violence.

(Source: No Limits monitoring data)

Stakeholders spoke about having established good relationships and communications with No Limits, with the programme being valuable and flexible. One stakeholder spoke about having established good relationships with No Limits having monthly catch-up meetings to discuss aspects, such as the number of referrals being sent over and whether these are appropriate. They also spoke about keeping in contact over e-mail as well. They spoke about communications working well and that there is a mutual appreciation and respect between the services, with open discussions and understanding of what each other does.

"I think the communication works particularly well. There's kind of a mutual appreciation between us and No Limits. They appreciate the work we do and we appreciate them being there. Because it's good for the nurse at the end of the triage to see somewhere they can signpost the young person to get them some support. I'm not going to diss mental health services, but sometimes they do fall off that cliff. They are in a gap and it's nice to have them to fill the gaps, as it were." (WS1)

"The help we do get is fundamental and it's so good and we do appreciate when they are in that they can help…I will always be referring people if they need it, even if it's, you know, and I think, when you go to an 11 year old and you say, oh, do you mind just filling this in a bit? And they're like mum and dad are like, well, what is this? I'm like, they're No Limits, a charity, they're just there for support and explain, that they fill it out, but they need parental [consent], you know, and they can tick it and they'll just give them a call. And at the end of the day, if they don't want to talk in two or three days' time, when they call them, you don't have to. It's just a referral to see if you need the extra help." (WS5)

The ED/SP Youth Workers were also seen to have an advocacy role in helping individuals to access different services, such as GPs and accessing appointments. Stakeholders described how Youth Workers often step in when CYP struggle to navigate these systems alone. Whilst CYP appreciated this support, it was noted that the outcomes of these efforts are not always positive. One stakeholder discussed the emotional toll when a young person finally attends a GP appointment only to feel dismissed and 'deflated' as they are not provided with the support that is needed. This is a particular challenge for those who *'don't have the best support networks at home' (N5)* where they have a parent or family member who can advocate for them. This highlights the fragility of trust and the risk of disengagement when services fail to meet expectations.

"…quite a lot of the time young people will say I can't get a GP appointment but…we [No Limits] can get them an appointment. So I think just external services knowing what we're doing, the roles that we're doing. It's just that just helps as well and it helps the young person." (N1)

"I've had it before where we've fought and fought, they've finally been seen [by a GP] and then they call me after and they're like…I just sat there and told them everything and they just said there wasn't really anything they could do. And I'm like, right, are they going to follow up with you? No. I was like, great, it's hard because then you've built them up to have the confidence." (N4)

"I am really grateful. I can never get hold of my GP and then you wave a magic wand, and they see me the same day!" (Young person, secondary data)

Youth Worker skill set and qualities

Youth Workers on the programme are seen to be 'highly skilled and experienced' and are able to deliver not only referral and signposting, but brief therapeutic interventions around, for example, reducing anxiety, self-esteem, psychoeducation and coping strategies.

The Youth Workers are seen to be consistent, flexible, and adaptable with an ability to build relationships with individuals because they are not from a statutory service (e.g., the Police, Social Care, CAMHS) and do not have 'an agenda'. The Youth Workers are seen to have a positive impact in

being able to advocate for individuals and trying to get them engaged/re-engaged with services where 'they've historically disengaged from' to 'foster positive relationships'. This includes, for example, linking individuals with community mental health teams and supporting CYP to engage with CAMHS, including sitting in on assessments. It was commented by stakeholders that the SP programme Youth Worker model lends itself well to CYP, but it was questioned whether it does the same for those younger adults (aged 18-25 years) and that it is important to develop and maintain relationships and integration with adult mental health liaison.

> *"I feel a real responsibility for changing their [the individual's] mindset on professionals…a lot of these young people have just been let down constantly by adults and particularly by professionals. So I found a real responsibility to make sure I'm not one of them. And, you know, helping them to be able to access support in the future when it may be needed." (N5)*

> *"A lot of the staff in the hospitals, they're just constantly feeding back to us that they just don't know how we managed to work our magic, how every other professional tries to engage with the young person, they're just not interested whatsoever and we walk in and get a totally different version of the young person. So it's always nice." (N2)*

Supervision

All No Limits delivery staff attend mandatory clinical group supervision every four to eight weeks depending upon their contracted hours. Targeted one-to-one clinical sessions are available to any staff who are in need of extra support, and this can be identified by the worker or their line manager.

Within No Limits, there is also an Employee Assistance Programme, provided by Health Assured, for staff and their families. This is a 24/7 service and can be accessed online or by phone. This is seen to be especially useful for ED Youth Workers if they have had a challenging late shift and need to 'download confidentially' so that they can 'leave work at work'.

Stakeholders spoke about the provision of line management and clinical supervision to the Youth Workers and that this is 'helpful' and 'robust' as it gives Youth Workers the space to talk about challenging cases and debrief. It was discussed that support is also available at any time should the Youth Workers need it.

> *"So we have like our supervisions with our manager, but then we also have a clinical supervisor, which I think is a really important space to have both myself and [name] when we've had, say, a difficult shift at the hospital, we've then had ad hoc supervision one-to-one sessions, which is very readily available, which is great." (N4)*

Barriers

Resource

Resource was highlighted as a potential barrier to delivery of the programme. Specific aspects that were highlighted included staffing, workspace and internet access.

Office space

It was discussed that for many of the No Limits teams there is no official designated space for the Youth Workers, with most being co-located in the hospital with other services (e.g., CAMHS), where there are limited numbers of desks to be spread across greater numbers of staff (e.g., three desks for

nine staff). It was discussed that Youth Workers often have to work elsewhere or from home for the last 1-2 hours of their shift in order to complete administrative tasks as the environments are not suitable, with Youth Workers unable to make calls to CYP due to lack of privacy. In response to space constraints, the No Limits Project Manager has been in discussions with stakeholders, such as the CAMHS Service Manager, to look at where alternative room space may be secured. Stakeholders also spoke about the importance of having safe and confidential spaces to speak to CYP.

Stakeholders commented about some services being 'territorial over their space' and that the rooms can be quite noisy so they *"either have to be unsociable and put in our headphones, or we have to take ourselves out of the office [and work somewhere else]" (N8).* The same stakeholder also noted that it could be difficult to find appropriate *"space to have one-to-one interactions with the young people"*.

> *"…we don't have like official spaces at the hospital…we're sitting with the CAMHS team…We're sitting with the safeguarding team or on the ward. There's a table where we kind of just sit amongst the staff and I think that's because of the good relationships that we've had. We've never really had an issue where we're like, oh, we can't be around here. We're just like, hi, guys, we're back. We're going to come and sit with you." (N4)*

It was highlighted, in Q3 of 2024/25, that the Youth Workers now have their own desks within the paediatrics department, which also includes additional space for storage as well as space to bring CYP so that they have a change from being on the wards. This was also seen to place the No Limits team in a better position to complete joint assessments.

Internet access

A few stakeholders highlighted that as the No Limits Youth Workers are non-NHS staff this means they rely on the free NHS wi-fi. This means that the connection can be 'patchy' and result in work being lost or not being able to access information about an individual before speaking to them/meeting with them. It was highlighted that secure networks should really be used when dealing with personal data and this could be achieved through the use of a dongle or Wi-Fi box to make it more secure.

> *"…it [the system] kicks you out. So then you have to sign back in and just refresh it constantly until it actually signs you back in and it's quite… But like you wanna write something down or you're about to see a young person, you wanna check before you go in there what it is that their history, or anything like that…" (N8)*

> *"…open networks and stuff is there's less security in them…If there was, I don't know even if it's one of those dongles or like one of them little portable Wi-Fi boxes that you get…It just makes it more secure and have a bit more of a stable Internet access..." (N3)*

Staffing

Levels of staffing were discussed as a challenge to the delivery of the programme. It was acknowledged in one area there had been an issue with long-term sickness and staffing that meant it had taken time to get the programme properly established and 'up and running'. As a result, it had been necessary for the new Youth Worker to go back into the ED and 'rebuild those relationships' because initial contacts that were made may no longer work at the hospital. It was also commented by wider stakeholders that there has been a high turnover of staff in some hospitals, which may have created challenges in terms of accessibility to the service.

"…when you don't have a worker over there for a period of [time]…And you've then got to go back in and hospitals being hospitals, all the people that we did know over there had left [and] gone somewhere else. So you've got to then rebuild those relationships then and now. The people are like, oh, OK, we don't know who you are because it's new members of staff within the hospitals." (N1)

"They [No Limits] basically had a bit of a turnover with staff, but they were always very keen to keep us updated with the new staff. We invite the new staff in here to see what we do." (WS1)

The Youth Workers have waiting lists and it was commented by a few stakeholders that the general reduction to four sessions is due to the growing demand for the service and ensuring that individuals are engaged with as soon as possible *"rather than having young people sitting and waiting and waiting" (N8).* One stakeholder commented that waiting lists were also hindered by lack of resource, such as understaffing, but that it had been possible for Youth Workers to call on support from other services where partnership agreements were in place.

"…there are instances where we can case hold for longer, but we've got the difficulties in terms of we should have two extra team members. So our waitlist and things like that we're under so much pressure to kind of get through that that sometimes you feel that you're kind of like just putting a plaster over it until they represent with something else sort of thing." (N4)

"…we've got a partnership with [organisation] project…So for a period of time when we had quite high numbers on our waitlist…They would take some of those referrals for us…So we might refer them in through the emergency department process, but then they would then keep hold of them and they've got different programmes that they can then refer into…" (N4)

It was discussed that what the No Limits staff cover is 'underestimated', with stakeholders commenting that the ED/SP Programme was doing as much as it could with the current resource.

"We're knowing them more and they've been there a while. We're very good at being like, have you done a No Limits referral…it's quite you know a struggle when there's only one person on and they've got to cover not only our department but adults and potential up on children's wards and you know that there needs to be more funding and there needs to be more money put into it to be able to get the service off the ground a bit more, but obviously funding is funding and it's a charity-based company…" (WS5)

Resource in relation to the presence of more Youth Workers on the programme was highlighted so that greater coverage could be given across the week to reduce missed chances for engagement. It was discussed that whilst the Youth Workers prioritise their caseload, and that generally it is possible to undertake everything that is needed each day, it is also important to consider their own safety and mental health.

"We'll try and see as many as we can, but also we have to take into consideration our own safety…our own mental health, and also if we've been dealing with a lot…you can either get caught up in that or like the admin side…Some days it's really quiet. Some days it is like really busy and sort of when it is busier you do wanna sort of…prioritise. It usually is who's been here the longest? And then and

then work out from there, or who is saying I'm gonna be discharged and then you've got to try and get in there before they say, before they leave the hospital and self-discharge." (N8)

Case holding

It was identified that the Youth Workers are providing more crisis intervention and undertaking more case holding than they necessarily should be. Stakeholders spoke about the benefits of being able to expand the current offer to one that included more case holding intervention workers that can case hold for a longer period of time (past the initial four SP contacts). It was felt that some of this may be associated with a lack of resource and capacity issues with services across Hampshire and the Isle of Wight. The programme was seen as filling a much needed gap, for example, in mental health provision that was previously filled by primary mental health or where there is a lack of long term community support for those in crisis. Youth Workers are holding CYP and their parents, providing support in the interim whilst they wait to be seen by other services. It was commented that outside of Southampton there is a limit on what is available in North Hampshire in terms of community-based support to be able to 'safely refer' individuals to with Youth Workers, therefore, resulting in case holding for longer. Stakeholders also highlighted that this lack of support can be age-related, with young people turning 18 and their access to a number of different avenues of support no longer being present due to funding being withdrawn across statutory and third sector services. It was also highlighted within No Limits reporting that with the SP offer, it can be more challenging to refer and signpost to additional support due to postcode restrictions for services and the scarcity of organisations available in the area who can provide long-term or intensive support. It was also highlighted that because of this, some SP sessions must adopt a more therapeutic approach to support CYP whilst they are on the waitlist for CAMHS or if they have not met the criteria for other services.

"[the Youth Workers are] doing more crisis intervention and case holding work... just to be able to extend the service and to have more case holding intervention workers…there's just not the services and young people don't always need counselling or targeted services, they just need a Youth Worker…somebody to be able to engage with…we already know six sessions doesn't work for counselling, but most counselling services are for six sessions. You know you need 12 realistically, to be able to make an improvement…" (N1)

"The way I see it is they [No Limits ED/SP] fill the gaps with the social prescribing. They can introduce them, they can understand what the young person needs and introduce them to these, to any other services they know of. Everybody is being referred to and that's the way the way I understand it is they, they, they have the time to engage with the young person." (WS1)

"I think it does compliment because I think that you know where they've only got those matter of a few sessions. You know there's work to do. They know that they can refer in to us and if they're waiting for CAMHS or MHST or whatever then, you know, hopefully they'll wait a bit less or they've got more support while they do wait for those specialised services. we do deliver therapy interventions different, we'll use different resources, but we're quite creative." (WS4)

It was discussed that due to this systemic lack of resource it is therefore important to utilise as many appropriate services as possible even where there may not be many. One stakeholder spoke about the Isle of Wight where there are not many services available, but it was felt that the Island maximises the services it has available. It is seen to be vital to cover all bases as CYP *are "slipping through the*

cracks and don't want to wait to see someone" (N3). The Navigator programme was seen to be bridging this gap and helping to support individuals whilst on waiting list for services but it was also acknowledged that this resource is not infinite.

> *"It'd be great if there were, I think probably more services around…just have all bases covered because what I'm finding is there's a lot of people that are just slipping through the cracks or, you know, as soon as they hear 'waiting list', they're gone… So I think if there was…a type of service or just anything that helps cushion the wait list… [No Limits] kind of gives a lot of these young people a bit of a bridging gap until they are then seen. But then there's only so much one person can do…there's only so many people that I can see where, you know, there's only so many people I can catch on that bridge..." (N3)*

Engagement

A final barrier that was identified was around the difficulty in engaging certain groups of CYP and younger adults, particularly where they are already entrenched in exploitation or criminal activity and where *'distrust of professionals'* exists due to previous experiences. No Limits reporting highlighted that many of the SP Youth Workers reported finding a lack of consistent engagement from CYP when arranging appointments or speaking via text. As a direct result of this, the SP team (as well as No Limits more widely) was able to set up WhatsApp on all work mobiles which was seen to have improved engagement.

> *"I think probably it's the young people that are already involved in the serious violent crime [that are the most difficult to engage]. Those that are sort of on the edge of getting involved or on sort of the younger age group, it's a little bit easier [to engage them], but some people that are sort of quite heavily involved in exploitation, drug dealing and things like that…[it] takes a lot more work trying to break down those barriers…but we always create those opportunities to be able to encourage that definitely…" (N1)*

Engaging with CYP (especially those who are looked after) and their families was also seen to be difficult to navigate and it was discussed that more engagement with Children's Services would be beneficial to help with this.

> *"I think we deal with so many children and young people that are either in care, so looked after children, or that are on a number of plans and that's sometimes quite difficult to engage, but it's also quite difficult to get the young person or their families to engage. So we try and foster those relationships wherever possible." (N1)*

Increasing the presence of the Navigator programme within certain communities where it is known to be difficult to engage individuals was a hoped-for objective for the future delivery of the programme.

3.6 Considerations for future delivery

Flexibility of approach

Stakeholders consider the Navigator programme to be valuable and that it should continue to work with flexibility with individuals to maximise the impact of the engagement that the Youth Workers have.

"It's handy to have that flexibility with them...where we can just adapt to their needs, even if it's just going to take a little bit slower compared to others…the journey is really about them, you know, about how it works for them. And we would just want to make sure that we can do whatever we can even as fast or as slow as possible with them, you know, to really kind of maximise our support with them." (N3)

It was discussed whether the option of longer case-holding could be explored, particularly where there is a long waiting list or an individual has a change coming up in the near future with which they need support and whether a partner organisation may take on this responsibility as a 'holding' referral partner. The focus on longer-term support was also discussed, particularly where individuals may not need counselling or therapy but would still benefit from lower-level support and a safe place to access it. Stakeholders suggested that this support may be provided in the form of a Hub for the under 25's that acts as an advice and drop-in centre where individuals may go for support around bills, writing CVs, drugs and alcohol, benefits, etc.

"What would be really great is longer case holding, whether that be with us or with an organisation that can then pick up some of it…I just feel like a lot of these young people need a bit more consistency for a bit longer. And some of them just need to be held while they're waiting for whether it be a wait list or just something else to come up. It could be around like they've got a significant change that's coming up in their life, which is a couple of months down the line. And actually they just need something that's consistent for that. So to have the flexibility and I guess…young people they just need longer term support and it doesn't need to be that I guess that level of counselling therapy, [more like] like lower-level support where they've just got a place to sit, talk unpick things. And just know they've got somewhere to go." (N4)

Increasing awareness and visibility

It was commented by a number of the stakeholders, that it would be beneficial to continue to promote and increase the visibility and awareness around the No Limits ED/SP service as some professionals may still not know about it.

"I think maybe the doctors aren't necessarily looking out to get them in No Limits referrals, some of them are really good about it. But I think just not everybody knows about No Limits." (WS3)

"I think people are aware that No Limits is there, but I think we need more teaching around what, No Limits do. I mean I know because…I work quite closely with them. But I think a lot of people they don't think you know when a young person comes in, 'oh I'll do a No Limits referral'…I mean that's not down to the No Limits team that's down to I think just general there's so much going on in emergency department sort of thing I think that but I think more promotion about what aspects they can help with…I think a lot of people don't realise what No Limits do. I think they think it's just a wellness centre and it's not, they cover so much more than just wellness…" (WS5)

One stakeholder spoke about recently finding out more about what No Limits and the ED/SP services provide over the last few months. It was felt that it is helpful to know that No Limits have an SP Youth Worker they can refer to when they identify a young person who might be in need of support.

"So I became more familiar with No Limits in terms of like sort of the services that they provide. Maybe in the last few months just sort of I got a bigger idea 'cause I always knew they were sort of associated with CAMHS, but actually I learned a lot more about them in the last like few months. And that helps, I think to that helps me to kind of have no limits just in the back of my head." (WS3)

Consistent Youth Worker

It is felt to be key to try and engage with individuals at that reachable and teachable moment and that this will be different for all CYP; for example, advocating for a young person to be seen by CAMHS sooner.

"I think that reachable moment is different for different young people, isn't it? So it might be a young persons on the CAMHS wait list and is very low down on that and presented at the hospital, but it might be that No Limits then raised that with a liaison service for them to reassess for risk and complexity…they play a role in terms of managing risk…also they're also trying to kind of support the young person to look at alternative." (N7)

The importance of consistency within this process was highlighted with individuals ideally engaging with the same Youth Worker once discharged from the ED; and stakeholders commenting that the Youth Workers could be the only 'constant' for a young person when they are 'carrying and dealing with a lot of stuff'.

Additional training

It was identified that there is the potential for additional training provision for Youth Workers that might specifically focus around the nature of ED work as well as eating disorders and how to manage those cases where the information disclosed is severe/intense, but also where positive outcomes may not necessarily be achievable due to long-term health conditions/where there is a poor medical prognosis for the individual.

"You don't know what you're going to be faced with [in the ED]. And my argument was you're working in ED, you gotta prepare yourself to sort of see the nature of these things…I don't often get very upset, but I've, you know, a couple of times I've gone…you know, that's got to me that one. And it's sort of like what training maybe could there be available to prepare ED workers…You know what level of it is you know taking the responsibility of knowing that you're gonna be working in ED To what can the service offer you, or what support can they offer you if it's in the NHS." (N4)

All-age liaison team

It was discussed that there is an aspiration towards an all-age liaison service/team approach that would embed the Youth Workers from the Navigator programme in a team including VCFSE, early intervention/prevention elements, and community support options. It was felt that this may also address issues around the estate and lack of designated office space and other infrastructure. It was felt to be important to look at integration across the ED and develop a shared understanding of the different skill mix and the benefits of this and also that not everything needs to be a clinically led model.

"I would like to see sort of going forward the future of that service being very much one service as part of an all-aged liaison psychiatry service. So how we do have our voluntary sector services really embedded in the triage and assessment and outcome of those young people. And that's very much how we can really support those young people of that early intervention and prevention element." (N6)

As part of this, an 'experts by experience' model was discussed, with specific focus around a volunteer programme that is being trialled in Southampton. It was commented that this programme is much needed and will have added value to the wider system with volunteers experiencing improved mental health and wellbeing and this could also lead to engagement in meaningful employment (paid or otherwise). Having such a programme was seen to be thinking creatively about how to *"improved outcomes for all our people by providing a potentially different workforce" (N6).*

"So they're using a volunteer model. They're gonna try it in Southampton Hospital first…It's also to maximise costs and, as we know, demand has gone through the roof. But actually NHS budgets haven't…you've got a lot of people with a lot of experience, a lot of compassion, who actually don't want to go into paid employment. And actually, some people are also on benefits and paid employment absolutely impacts those benefits. But to be able to sort of add value back and sort of feel part of that employment sort of society that actually it does help people's mental health and well-being. So I think it's an absolutely phenomenal opportunity and sort of really sort of encourage that across all of our organisations…that could lead to paid employment going forward and then that person sort of comes off benefits or actually feels like that, they're sort of adding more value because they then go into paid work and for some people, they probably have never been into paid work." (N6)

It was also felt that a peer model for those aged 18-25 years could be beneficial.

"I think that peer model lends itself well to that kind of 18 to 25 cohort because within adult mental health that model appears supports more kind of not accepted. But it's more kind of common than peer support within the kind of younger age." (N7)

Funding

Stakeholders commented that due to funding it was not possible to have the No Limits staff present in the ED all the time. It was felt that this was managed well through the consent to contact forms, however, it was hoped that further funding might be found to increase the available resource to have No Limits available every day of the week from 8am to 8pm.

" Ultimately there isn't the funding to have the Youth Workers in the ED… I would want Youth Workers in the ED every single day… I mean, I think they handle it and manage it brilliantly. They've got this consent to contact [form]. So I think that process is a really good process for reaching out to those young people [who can't be seen on admission]…I like a referral form because I think that if you tell a young person go here, go there, some of them might have families that might support them, but my experience working young people is that they might not do it because they fear, whereas if you refer them and someone calls them like those consent to contact. Then someone's gonna have another conversation and go.

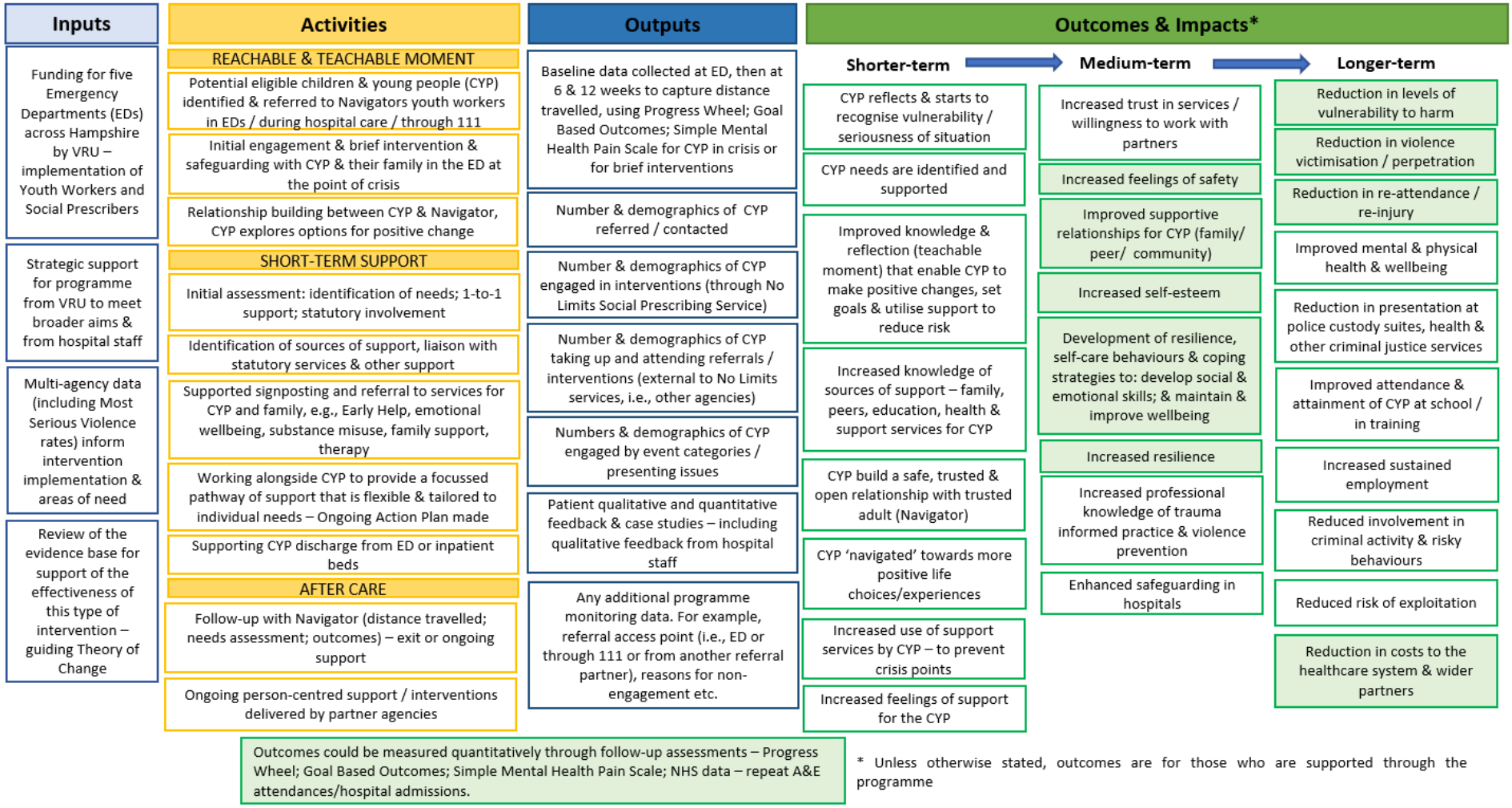
You know, what are those barriers? What can I do to help get you into these services?" (WS4)

"There's not enough people to cover service…we would need somebody from like 8 in the morning till potentially like 8 at night. But they don't have that service. They don't have that volume of people to be able to do that." (WS5)

4. Logic model

From the evaluation activities, a logic model has been developed that identifies key activities, outputs and hoped for/actual outcomes of the programme (Figure 3).

Figure 3: Hampshire and Isle of Wight (ED/SP/111) Navigator Programme - Logic Model



5. Summary of key findings and recommendations

5.1 Implementation

Delivery, programme recruitment and support pathways

The No Limits (ED/SP/111) Navigator programme works with individuals aged 11-25 years who present at any of the five EDs across Hampshire and the Isle of Wight. The programme is a hospital-based violence prevention programme that seeks to support and engage those who present at hospital having experienced violence or being at risk of violence, crime or criminal activity (e.g., drugs, gun crime, county lines, exploitation) or presenting with other related vulnerability (e.g., substance use, mental health issues [eating disorders], homeless, runaways). High levels of those who present at the ED and engage with the ED Youth Workers and subsequently the SP programme have mental health issues (e.g., attempted suicide, self-harm, eating disorders, anxiety etc.). This is evident in both the quantitative data and interviews undertaken with stakeholders who highlighted they aim to provide holistic and tailored support to the individual that can be around a number of different aspects.

Currently, Youth Workers and two volunteers from the programme as well as NHS staff partners engage with individuals when they are admitted to the ED/a hospital ward. They listen to the young person's experience, identify any protective factors, and discuss their support needs. Referrals are then made (via a consent to contact form) from the ED/a hospital ward to the SP arm of the programme. There are also two dedicated Youth Workers who triage referrals received from the NHS 111 mental health triage service, which is delivered by Southern Mental Health and covers Hampshire and the Isle of Wight. Engaging with individuals at that 'reachable [and teachable] moment' is perceived by professionals as a key 'window of opportunity' for crisis management that can begin to help CYP to realise that there is someone there to listen and empower them to start their support journey. Where CYP do not engage with the ED Youth Worker and/or the SP Youth Worker support, they are provided with key contacts for support (e.g., a 'stay safe' card, leaflets detailing of useful self-help apps; crisis support and looking after your mental health booklet providing information about the No Limits Advice Centre and mental health support, crisis support contact information for other organisations, the mental health pain scale as a tool to help YP explain how they're feeling; and details of Portsmouth support services for U18s, useful apps, tips for helping anxiety etc.), and may also be referred onto other more appropriate services such as DASH for support with drug and alcohol use, or homeless charities for support with housing (where SP support may not be appropriate). Whilst there is an approximate 3-4 week wait for SP support to start, the young person is usually contacted within 24 hours of the consent to contact form being completed, which was seen to provide reassurance.

Social Prescribing

The SP Youth Workers provide a standard four sessions of engagement. These sessions may be undertaken in a hospital setting where a young person may be an inpatient, but are typically undertaken once the young person is in the community through a number of ways including telephone, text message and face-to-face. More recently, this has also included being able to engage with CYP through WhatsApp. This number of sessions was seen to help reduce waiting lists for the programme and provide more structured engagement that has a positive impact for both individuals and Youth Workers. The SP model has always been four sessions, with increases in engagement not being due to procedural change, but instead due to the organic needs of the CYP (averaging around six to eight sessions). Some were extended beyond this where there were safeguarding concerns or

complex needs with no other organisations available to take the young person on for support. SP Youth Worker support can include the delivery of brief therapeutic interventions and, therefore, does not follow a traditional SP model of signposting and referral. The engagement is goals-based and identifies areas where support is needed whilst allowing individuals to be 'reflective' about their current situation. This also helps the Youth Workers to identify areas that may need to be explored further. The adaptable and flexible way in which the Youth Workers engage works to maximise the impact of contact with each individual. Youth Workers also have the ability to develop relationships of trust with individuals because they are not statutory services and this enables them to act as advocates. Stakeholders spoke about Youth Workers having access to lots of different resources that give individuals the freedom and opportunity to explore and try new things. The duration, frequency and the way in which engagement takes place varies depending on this need.

Key facilitators and barriers

Developing connections

It was clear through the evaluation that good connections and relationships have been established with key partners within the hospital setting and this (along with wider stakeholder relationships) was a key facilitator to the success of the programme. The Youth Workers make themselves visible and are embedded into hospitals. Placing No Limits staff within different teams (e.g., CAMHS and VAST) was seen to provide wrap around care for CYP. Joint visits are also undertaken with specialised professionals, who are able to bring their own experiences to enhance support for CYP and improving outcomes (e.g., with Youth Workers helping clinical and mental health decision making leading to, e.g., discharge/early discharged [paediatric psychiatric liaison team – PPLT]). Referral partners cover all aspects of health and wellbeing (e.g., mental health, drug and alcohol use, domestic and honour based violence, sexual health and sexual violence/abuse, neurodiversity, young mum groups, safe house, housing, advice centre etc.). They perceived the Youth Workers as engaging well with them. This ensures that the programme is able to make the most of the resource that is available in each locality. It was evident through the evaluation that there is also strong internal partnership working within No Limits, with the Navigator programme and the No Limits Advice Centre and Safe Haven Programme providing wraparound support and facilitating conversations between CYP and services. These look to address underlying support needs for CYP and can provide more than the standard four SP sessions available through the (ED/SP/111) Navigator Programme. Referrals into Safe Haven can involve more in-depth crisis work (e.g., where self-harm which eliminates them from MHST support but is not high enough to breach for CAMHS), whilst referrals to the Advice Centre may be around a number of support issues such as welfare, mental health, housing and legal advice. Another avenue of support from No Limits is the newly formed MHST (from October 2024), however, this is currently only available in Southampton.

Skills and resources are shared between Youth Workers and they also provide peer support to each other. Youth Workers also have access to clinical and manager supervision for support. Appropriate training opportunities are also provided for the Youth Workers, and they are also able to request training where they feel it is necessary.

Resource

Resource was identified as a key challenge within delivery of the programme, for example: lack of designated office space for Youth Workers (although this was detailed to have been rectified in one hospital where the staff had been provided with desks and a space to bring CYP); poor internet access with Youth Workers having to use free NHS-Wi-Fi, which also is not secure when viewing client data; a high turnover of staff in some hospitals creating challenges in terms of accessibility to children and

CYP; and, the need for greater coverage of staffing across the week to reduce 'missed chances for engagement'.

Systemic lack of resource and capacity within services across Hampshire and the Isle of the Wight was also identified as a challenge, with the (ED/SP/111) Navigator programme bridging the gap to accessing services. It was identified that there is a gap in mental health provision, particularly in certain areas of Hampshire where there is limited community-based support to 'safely refer' CYP to. Exiting services often do not provide long-term or intensive support, resulting in the SP Youth Workers case-holding for longer and providing more crisis intervention. There was discussion of the role that a Hub for the under 25s may have (there is currently a Hub in the Southampton No Limits Advice Centre) that would act as an advice and drop-in centre for individuals to provide practical (e.g., bills, welfare benefits and CV writing) and health and wellbeing (e.g., drug and alcohol use, mental health) etc. support. In addition, the role of an experts by experience model and a volunteering pilot programme was discussed as a way in which support current resource/capacity issues.

Future delivery

When exploring future delivery, stakeholders highlighted that the Youth Work model lends itself well to children, but that the benefits and impact of the programme upon younger adults (18-25 years) may not be as clear. It was discussed that there is an aspiration towards an all-age liaison service/team approach that would embed the Youth Workers from the Navigator programme in a team including VCFSE, early intervention/prevention elements and community support options. It was felt that this may also address issues around the estate and lack of designated office space etc.

Stakeholders also discussed promoting and increasing the visibility and awareness around the (ED/SP/111) Navigator programme. They also discussed that if it were possible to increase funding for the programme, this could increase the presence of No Limits staff to every day of the week 8am to 8pm.

Recommendations for implementation

Based on evaluation findings, a number of recommendations were produced, which aim to strengthen the programme's delivery, ensure appropriate recruitment, and enhance support pathways, thereby maximising its impact.

- Continue to enhance the reach of the programme through engagement and collaboration with key stakeholders who can promote and advocate for the programme and also provide feedback around the programme delivery, making changes in real-time where possible.
- It is important for the programme to continue to embrace the adaptable engagement methods for the SP model, as well as looking at whether additional digital tools, such as secure video calls could also help to enhance access to the SP. Ensure that any delivery methods cater to the diverse cultural and linguistic needs of the target population, ensuring inclusivity.
- All support documents such as the 'stay safe' cards and more recent physical (e.g., booklets)/online resources and support tools should be regularly updated to ensure the information is up to date, but also that they meet the evolving needs of CYP accessing the programme, incorporating feedback from key stakeholders. Keep the materials up to date with current issues, trends, and the latest resources, such as mental health apps or online support communities.
- Build on the existing success of the hospital-based collaborative working practices/relationships and stakeholder collaboration to ensure the maintenance of comprehensive wraparound support.

Explore whether/how best practices may be formalised with clinical and mental health staff as standard practice to foster teamwork and also how these practices may be replicated across other locations.

- Continue to develop relationships with wider stakeholders (e.g., community groups) to identify at-risk CYP who may not currently be accessing support through the programme (underserved groups) but would benefit from doing so. This may also be supported through the data.
- Continue to expand the volunteer model and ensure that enhanced training opportunities are provided to volunteers to strengthen their roles in the programme. Look at ways in which to recognise and retain their voluntary commitment. A structured volunteer programme will create additional capacity for non-critical engagement.
- Maintain and expand access to clinical supervision and skills training for Youth Workers. This may include the introduction of specialised training modules focussed on trauma-informed care, to ensure that the Youth Workers and volunteers have the necessary tools and skills to be able to undertake their roles, whilst also being able to safeguard their own mental health and cope with challenging cases.
- Explore the referral pathways between the programme and other No Limits services (e.g., Advice Centre and Safe Haven).
- Continue to provide SP based upon individual circumstances. Explore whether the current SP offer could be expanded to include more 'case holding' intervention workers who would manage those cases that require longer engagement (e.g., more than the standard four SP sessions; those who are long-term stays on wards) or are more complex. It may be explored how No Limits could partner with internal and/or external organisations to manage these cases collaboratively (e.g., 'holding' referral partners). Any changes to delivery of the model need to ensure that manageable workloads are maintained for the Youth Workers.
- Continue to implement a robust feedback system where CYP and stakeholders can share their insights on their experiences with the programme, allowing continuous improvement. This may also involve gaining insight into whether there is an appetite for an 'experts by experience' initiative where former programme participants provide peer support and advocacy.
- In order for the programme to be delivered efficiently and successfully, further exploration is needed to look at how barriers to programme delivery may be addressed. This could include: 1) Dedicated private office space to ensure secure, confidential, and effective client interactions. 2) Developing partnerships with hospitals to co-invest in infrastructure improvements, including secure Wi-Fi access for Youth Workers handling sensitive data – this may include exploring portable and secure internet solutions (e.g., mobile hotspot devices) to eliminate dependence on NHS public Wi-Fi. 3) Looking to address systemic barriers, such as accessing alternative services and advocate for increased resources through providing an evidence-base around the impact of the -programme.
- Suggestions were made around an all age liaison service model that integrates prevention, early intervention and community support. Embedding the Youth Workers within this service and having this integration across the ED would enable a greater development of a shared understanding of the different skills and the benefits of this and also that not everything needs to be a clinically led model.
- Engage with funders and commissioning bodies to sustain long-term investment in the (ED/SP/111) Navigator programme. This will include working with funders etc. to advocate for and secure increased funding for programme expansion e.g., additional staffing and extending operational hours to 7 days a week (8am to 8pm).

5.2 Outcomes and impacts

There are clear aims and outcomes of the (ED/SP/111) Navigator programme that are detailed in the programme logic model. These are across the short, medium and longer term and can be seen at individual, family/community and wider systems levels.

It is evident through the qualitative data included in this report that there is an overwhelming feeling that the Navigator programme is achieving a number of hoped for outcomes on an individual, family/community and system level. These focussed around:

- Building positive relationships/developing relationships of trust with CYP, helping them to feel supported in discussing aspects of their lives they may not have talked about before (e.g., first disclosures).
- Improving health and wellbeing, e.g., increases in confidence, empowerment, self-esteem, resilience, reduced isolation, improved self-care, through access to/engagement with services, CYP with eating disorders beginning to enjoy hobbies and socialising again, with an overall increase in emotional resilience). Findings from the monitoring data showed that of the 118 cases which had pre and post data on the Simple Mental Health Pain Scale, there was a statistically significant decrease in mean score from pre to post assessment (pre, 7.18; post, 4.78; $p<0.001$) indicating a positive change.
- Improved physical health, e.g., reduction in the number of individuals who self-harm, CYP reducing or stopping the use of drugs and alcohol, taking prescribed medications more regularly etc.
- Increased school attendance in those with EBSA.
- The support parents/carers received was perceived as improving relationships between parents and CYP.

The hoped for medium to longer-term outcomes of the programme included reducing violence and admissions to ED with aimed impact of reducing pressures on the health, social care, and criminal justice systems.

Recommendations for implementation based on individual, family/community and system level outcomes

Evidence from the evaluation suggested a number of recommendations for the Navigator programme that build upon the programme outcomes.

- Individual level-outcomes can be further strengthened through the continued use of tailored support plans that help to sustain improvements in areas such as self-confidence, resilience and self-care beyond engagement with the Youth Workers. It may also be explored whether with additional resource, access to therapeutic services (e.g., group therapy, peer support networks) may be expanded to further reduce self-harm and strengthen resilience. This could be done in collaboration with local mental health services to address gaps in support for those with complex cases.
- On a family/community level, with consideration of resource workshops or family therapy sessions could be developed to help parents/carers strengthen their relationships with their children. Resources tailored to parents, such as guidance on supporting CYP's mental health and coping strategies for challenging behaviours could be developed. The programme can also continue to build upon partnerships they have developed/are establishing with local schools, youth organisations etc. to identify and support CYP with EBSA and other challenges.

- When exploring system-level outcomes in the longer-term, it is important to utilise outcomes data to advocate for additional funding by demonstrating the programme's effectiveness in reducing ED admissions and how the programme may help to alleviate pressures on health, social care and criminal justice systems.
- The evaluation highlighted a level of unmet need regarding mental health provision and findings from the evaluation can support partners to advocate for funding for provision regarding this.

5.3 Evaluation and monitoring

Whilst the monitoring data provided further evidence on the dose and reach and impact of the programme to date there are a number of considerations for its use in future evaluation.

- No Limits run quarterly reports on their data as standard monitoring practice, and this aggregated data is then provided to the VRU and the evaluation team. However, as this is collated data it does not lend itself to more complex analyses (e.g. examining associations between variables) or case studies of CYP's journeys. Individual-level data covering all cases can also be provided by No Limits. However, this requires additional work by No Limits and because of the way the monitoring system works, this individual level data is pulled off the system in separate Excel outputs. Within each of these datasets CYP have an ID which can then be used to match their information across datasets. However, this is a lengthy process and is further complicated because within the interactions dataset each interaction is represented as an individual line of data and, in Year 1 of the programme, it had over 10,000 lines of data. Because the dataset included individuals who had accessed the service prior to the current commission the client ID for each action had to be manually cross-checked against the referrals dataset to ensure they fell within the current commission period and should thus be included in the analysis. Furthermore, for each action several 'events' (i.e. needs addressed by each action) are recorded in a separate dataset as an individual line and, in Year 1 of the programme, there were almost 30,000 lines of data recorded. Due to the number of lines in this dataset it was not possible to manually match event data to client ID to ensure they fell within the current commission period and thus a quantitative analysis of events data was not undertaken. As a result of the data being captured in this way, it is also not possible to link the dose of the intervention each young person receives to other factors such as demographics, reason for presentation, and outcomes. These factors only have implications for evaluation including the ability to do more complex analyses, however, the primary purpose of monitoring systems, such as the one No Limit's uses, is for internal monitoring and recording of individual's data and support provision and for these purposes, the system works well. Given the complexity and resource required to extract and analyse this data we present a subset of individual level data analysis from Year 1 in this report.
- Reason for presentation was originally recorded as the reason for presentation to the No Limits support service rather than the reason for presentation to ED. However, this was flagged as being an issue and has now been changed to reason for presentation to ED.
- Identified risks are currently recorded in the dataset as risk 1, risk 2, risk 3, etc, rather than a variable for each risk (e.g. emotional wellbeing, safety) which is then recorded as present or absent for CYP. Significant data cleaning was undertaken to recode risks into categories in order to perform the analysis. If risks were recorded as present or absent it would also mean analysis of the level of risk and the action required for each risk for each individual was amenable for analysis. Whilst significant data cleaning is required to understand risks at the individual level, risk data can more easily be pulled off as collated data which details how many CYP experience each risk. Given

the complexity and resource required to extract and analyse this data we present a subset of individual level data analysis from Year 1 in this report.

- While data is currently captured by the system on reasons for case closure, this also does not easily lend itself to analysis to inform the evaluation at an individual-level. This is because CYP may reengage with the service and so have multiple entries and reasons for exit from the service. This is not a weakness of the monitoring system but a factor of the nature of service provision that CYP may engage for a period for support and then reengage at a later time point. Given the complexity and resource required to extract and analyse this data we present a subset of individual level data analysis from Year 1 in this report.
- A case record is only created for individuals who work with the social prescribing team. Individuals who are referred but are only seen in the ED do not have a case record created due to the briefness of the interaction and so less detailed information is captured on these CYP. This makes sense considering the ED teams may only meet a CYP briefly on one or two occasions and capturing and recording this information would involve taking time up in these brief interactions which could otherwise be used to deliver the brief intervention. A flag on individuals who only received support in the ED would support more in-depth analysis of any differences between individuals receiving the ED brief intervention and those accessing further support with the social prescribing team.
- Initially, there was consideration of using WEMWBS and SWEMWBS to monitor mental wellbeing outcomes, however, anecdotal evidence from Youth Workers suggested that CYP did not like completing this measure and Youth Workers perceived the collection of this data as a barrier to building a trusted relationship with the young person. This is an important consideration when using outcome measures as part of monitoring data. A balance must be found between measures which are acceptable to CYP and informs their support provision and those which will provide evidence of impact. Following a service review of the outcome measures which could be collected, the decision was made to use the Simple Mental Pain Scale (in the ED) and the Progress Wheel (in SP). At the time of writing only the Simple Mental Health Pain Scale had been conducted with sufficient numbers of CYP to include in the current evaluation report analysis. Whilst the Simple Mental Health Scale is not a robust outcome measurement tool, it is appropriate for use in the ED where, after a brief intervention, other tools which measure impact are unlikely to show change (e.g. SWEMWBS, the Progress Wheel). Data from the Progress Wheel will be analysed and included in the Year 2 report.
- Other ED Navigator programmes have added a Youth Worker assessment of risk/needs at case closure to provide another measure of impact. These can be done jointly with the young person or based on the Youth Worker's knowledge. Another potential data field which could be captured and would be useful for informing the risk profile of individuals accessing the service is if they had ever attended an ED in the past five years for assault-related injury.

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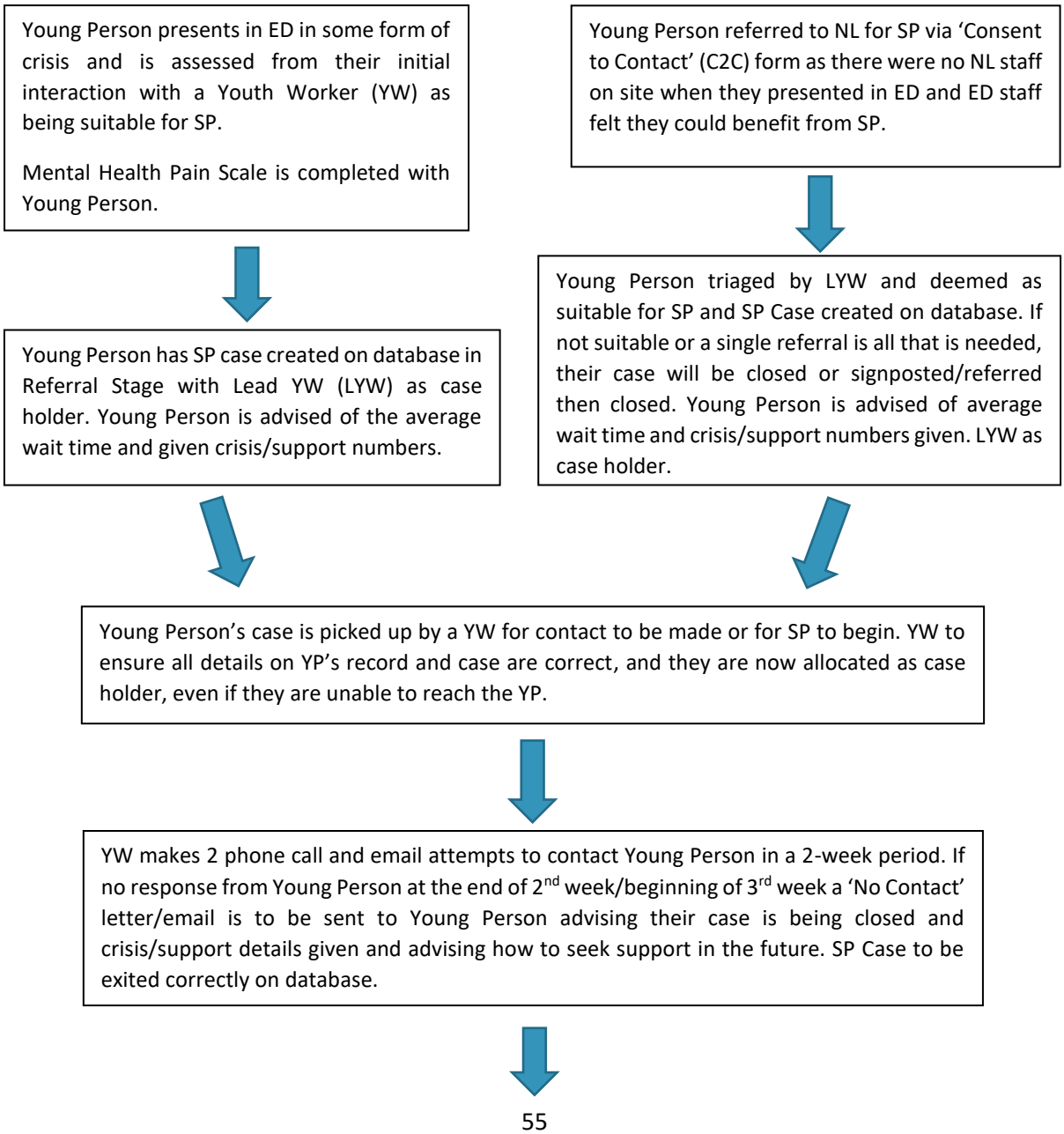
7. Appendices

Appendix 1: No Limits (NL) Social Prescribing (SP) Flow Chart

Social Prescribing is offered to children and young people who would benefit from being linked to local services and groups which they may not be able to easily access on their own. Access to these services will help them to improve their wellbeing. The core principles of social prescribing are that it:

- Is a holistic approach focussing on individual need.
- Promotes health and wellbeing and reduces health inequalities in a community setting, using non-clinical methods.
- Addresses barriers to engagement and enables people to play an active part in their care.
- Utilises and builds on the local community assets in developing and delivering the service or activity.
- Aims to increase people's control over their health, wellbeing and lives.



If Young Person responds to YW and wishes to proceed with SP, an initial assessment is booked. During the assessment stage, the YW looks to identify the needs of the Young Person and any vulnerabilities or risks and sets clear goals.

YW arranges the 'First Appointment' with the Young Person and creates a plan of what they need support with and what the remaining sessions will look like. The Young Person has 4 SP sessions: Assessment, First Appointment, Ongoing Appointment, Final Appointment. Any cases with more than 4 appointments, needs to have a clear plan in place, rationale and discussion/agreement with LYW. An action plan will need to be added to the case for more than 4 sessions.

The 4 SP appointments can include F2F appointments, virtual video calls and phone calls. F2F must **ALWAYS** be offered to the Young Person as the preferred choice.

YW's responsibility to ensure that the case is managed correctly on the database and that interactions are added within **48 hours**. Minimum of **ONE 'Event'** to be added to every interaction with the Young Person.

YW's responsibility to ensure the first SP Progress Review outcomes are added to the case as well as any 'Actions' to be completed during their SP.

At the end of the SP, the YW must ensure that the final SP Progress Review has been completed and the outcomes added to the case on the database. All referrals added and actions documented **MUST** have the final outcomes added on the database.

The YW must send the Feedback Link/QR Code to the Young Person.

The case must be pulled through correctly on the database 'Bullseye' to discharge and then exit. **The exit date must be MANUALLY inputted** and saved before the case will exit correctly.

Appendix 2: Further case study examples

Presenting condition/situation on presentation:

Presented at ED having tried to take their own life.

The YP stated she did not wish to stay at her social care placement due to the way the staff treated and spoke to her. YP didn't feel heard when voicing her concerns so tried to take her own life to be admitted into hospital. The YP said she did not want to die but felt it was the only thing she could control. The YP is currently under a strict Deprivation of Liberty Safeguarding Order.

Contextual vulnerabilities:

- Historical sexual abuse
- Self-harm
- Risky behaviour
- Removal from school
- Self-destructive behaviour

Female – aged 14

Engagement with the Youth Worker (YW):

The YW supported the YP over a five-week period from ED admission to discharge from ward before a new care placement could be sourced. YP engaged well and asked for support with specific subjects, such as healthy relationships, sexual health, and managing emotions alongside engaging with the YW to play a game or just have a general chat. YP actively asked medical staff/care home staff that the No Limits YW be involved in supporting them whilst admitted in hospital. YP discharged to new care placement.

"I really look forward to No Limits visiting me and the effort the Youth Workers have made to support me". (YP)

Source: No Limits secondary data

Presenting condition/situation on presentation: Presented to ED having taken an overdose.

The YP had been at a party where he learnt his ex-girlfriend was in the vicinity; this information threw him into a state of panic and worry as the relationship had been very toxic, and he had suffered emotional, mental, and physical abuse during the time they were together. He went home but had no one to talk to and due to having consumed alcohol that night along with his feelings of isolation. He felt his only option was to take an overdose. His parents weren't aware of this, but he managed to find the courage to tell his friends, who supported him to ED where he got the help needed.

A Consent to Contact Form was completed (due to the time of admittance into the ED) and a YW was assigned for social prescribing.

Contextual vulnerabilities:

- Self-harm, overdose and low self-esteem.
- He had been in previous unhealthy abusive relationships and had unresolved bereavement/grief to manage

Male – aged 16

Source: No Limits secondary data

Engagement with the Youth Worker (YW): An initial face to face assessment and completion of the Progress Wheel identified support was required for mental wellbeing, school, and relationships and he wanted to prioritise mental health (MH) and school. YW worked alongside school regarding his attendance, which was at 83% and explored sleep hygiene as he struggled to get out of bed on time due to inability to sleep at a reasonable time, drawing up a plan of action.

It was also identified during engagement that the YP had experienced bereavement with a referral made to 'SimonSays' child bereavement support charity. Signposting and referrals were also made to Motiv8 and Havant Mind Safe Haven. Healthy relationships were discussed, and it was explored what this looks like within a relationship and how female to male abuse is prominent. YP has been allowed a safe space to discuss and explore the feelings of shame that he has carried. He is in a relationship now and this appears to be healthy. Sexual health/safe sex has been discussed.

The support from the YW is seen to have increased confidence, addressed concerns and allowed safe discussion for this YP. The YP was very proactive in attending sessions and will engage and listen to advice and support offered.

Upon discharge appropriate signposting was also given for MH services and support services as well as a crisis support plan and MH first aid box.

Presenting condition/situation on presentation: Attended ED on her school's request after an overdose of paracetamol and ibuprofen.
YW was informed by clinical staff that there were suspicions of unhappy/unsafe home life. Dad had been very aggressive in the ED towards YP and staff, he had taken YP's phone and then left.

Contextual vulnerabilities:

- Self-harm,
- Suicide attempt,
- Abuse (possibly honour based)

Female – aged 13

Source: No Limits secondary data

Engagement with the Youth Worker (YW): YW met YP in the ED. She was very shy and reluctant to talk about family or mental health but would be open to talking about her friendship group and sports. After a while YP began to open up about home life and relationship with parents, YP disclosed that she has two younger sisters and feels the need to protect them from her parents. YP spoke about physical and emotional abuse at home.
YW disclosed this information to the Safeguarding Team - YP said she was okay with this. YW stayed with the YP in the ED for a few hours and then took YP over to the ward. YW spoke with the safeguarding team who worked together to support YP. YW stayed with YP for a while longer, playing some games and chatting to make sure YP was okay by themselves on the ward.
The YW will see YP at school for regular check ins and emotional support and will also follow up any actions agreed following the safeguarding disclosure to the hospital.
Staff involved with this YP's case stated that *"We appreciate the amount of time and energy you have for [name]."* commenting that *"The work you have done with [name] is incredible and should not be overlooked."*

Presenting condition/situation on presentation: The YP was brought into ED by her Dad. YP had taken overdose as she felt she didn't want to be here anymore as she's not comfortable in her own skin and hated how she looked.

YP was very tearful and despondent saying *"I feel silly now but I just hate myself, the way I look, how tall I am and that I just don't fit in with other girls at school"*. YP was dreading prom and any other social events saying, *"I can't make myself shorter or smaller".*

Contextual vulnerabilities:

- Suicidal ideation
- Overdose
- Low self-esteem
- Body image

Female – aged 15

Source: No Limits secondary data

Engagement with the Youth Worker (YW): The YP and YW talked at length about the YP feelings of being uncomfortable in her skin. They spoke about the YP likes and how she used to play football on a boy's team but would like to join a girls team once she leaves school; this included looking online at lots of different female footballers and how they are all different shapes and sizes. The YP said that she had never thought of it like that before. The YP and YW spoke about plans after school and the prom and identified explored thoughts around the best and worst things that could happen. They also discussed sleep hygiene, nutrition, and kind self-talk. The YW showed the YP the Mental Health Pain Scale (MHPS), which the YP was really interested in. It was suggested she use it as a check in every few days and to let her Dad know if she needed support.

Follow up: When the YW met with the YP at a social prescribing session, the YP said she had been using the MHPS in school and school were now using it daily to check in, including with other students. The YW gave her some more that she could take into school. The YP told the YW that she planned to go to prom saying she felt 'more accepting' of herself.

At the time of her final check in, the YP had attended her prom and said she 'loved it', she was happier in herself and has had no further suicidal ideation, self-harm or overdose attempts and her plan now is if she feels low, to use her MHPS, use the wellbeing journal YW provided and to speak to Dad if she is struggling.

"I am so grateful to NL and [YW] for being there when I needed someone to hear me out and not make me feel silly. [YW] did that and she also helped to see things differently. I wouldn't be here or have gone to prom without [YW] encouraging me. My dad thinks this service is brilliant and valuable to the hospital and the children you see". (YP)

Situation: YP is currently inpatient in hospital being treated for an eating disorder. She needs restraint for feeds via a nasogastric (NG) tube by three RMNs (registered mental health nurses), alongside the support of two clinical staff. Whilst on the ward, YP has been self-harming due to increased distress with re-feeding plan.

Contextual vulnerabilities:

- Anorexia
- Barriers to engaging with support
- Self-harm
- Suicidal thoughts

Female – aged 13

Source: No Limits secondary data

Engagement with the Youth Worker: YP is seen regularly by YW in the hospital. On this occasion, the staff asked for help to engage the YP and to encourage her to remove distressing and negative comments she had written about herself on her window (using window pens).

YW went to see YP for engagement with mood cards. YP engaged very well with the mood cards and wanted to identify which of the cards she felt related to how she was feeling, she wanted to answer the questions and read the affirmations and picked out those affirming statements which she felt she connected with. Once this activity was completed, YP asked what affirmations were and how they help. YW explained these were great for either reading or saying out loud and how it can also be positive to write them down. YW suggested YP writes them on her window as a reminder and as something she will see regularly but explained this would be difficult to fit in around the negative comments. YP agreed and cleared all the negative comments off their window and replaced them with positive affirmations and then asked for the YW to add some word art and additional positive comments.

During this interaction, the YP had to have food replacements through a NG as part of her treatment. This is something that the YP finds very distressing and usually requires three RMNs. Due to there being a shortage of staff, the YW supported the YP to be calm enough and feel safe to enable them to comply with feed with just the support of clinical staff. YP underwent the whole process without being restrained, with the YW and staff ensuring the process was taken step by step with enough support and encouragement to keep YP feeling safe so there was no violence or refusal requiring restraint from RMNs or feed not being completed. This was the first time this had been achieved throughout the YPs current admission and the YP felt more in control of her care.

YW supported YP afterwards to discuss negative emotions and feelings that came up as a result of the feed. The YP was able to share these feelings and have a safe space to work through them which was then followed by mindfulness activities and a game to help distract.

"You're always so nice to me and I still don't feel like I deserve it. I wouldn't have been able to do today without you. I also love my new window. Thank you for taking the time you did with me today." (YP)

Presenting condition/situation on presentation: YP admitted following self-harm and low mood. YP had been self-harming for two years, which began after issues with body image and friendship struggles in school. College was a major trigger for her anxiety, and she felt constantly overwhelmed by her academic workload and social expectations.

Contextual vulnerabilities:

- Anxiety
- Pressure in personal relationships
- Self-harm

Female – aged 18

Source: No Limits secondary data

Engagement with the Youth Worker (YW): During the first SP session, the YP was very open about the challenges she was facing. She felt nervous about seeking help from the College's well-being team, despite knowing they were available. With support from the YW, the YP reached out to the well-being team and as a result, began counselling. The YP was also feeling pressured by her friends in her new relationship to have sex and unsure of how to manage the situation and wanted guidance on how to manage those feelings. The YW and YP talked about consent and how to recognise and handle the pressures she was feeling. The YW provided resources on consent and referred the YP to a sexual health clinic to discuss contraception etc., empowering her to make informed decisions.

The YW and YP also explored coping mechanisms the YP had started using in her day-to-day life, and worked together to create small, achievable goals and steps (incl. exploring how the YP may look to change her job without it feeling overwhelming).

The YP is now in a much stronger place mentally and has made significant progress in feeling more confident and resilient, as well as becoming more assertive in navigating personal relationships and setting. She also has more clarity about her future and goals. The YP expressed that she feels more in control of her anxiety and is ready to apply the identified coping strategies. She had also not self-harmed for 5 months. The YP wanted her final SP session to be a celebration, eating cake and reflecting on the progress they have made.

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PUBLIC HEALTH
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NO LIMITS
Helping Young People Help Themselves

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