Comisiynydd yr Heddlu a Throseddu De Cymru
South Wales Police and Crime Commissioner

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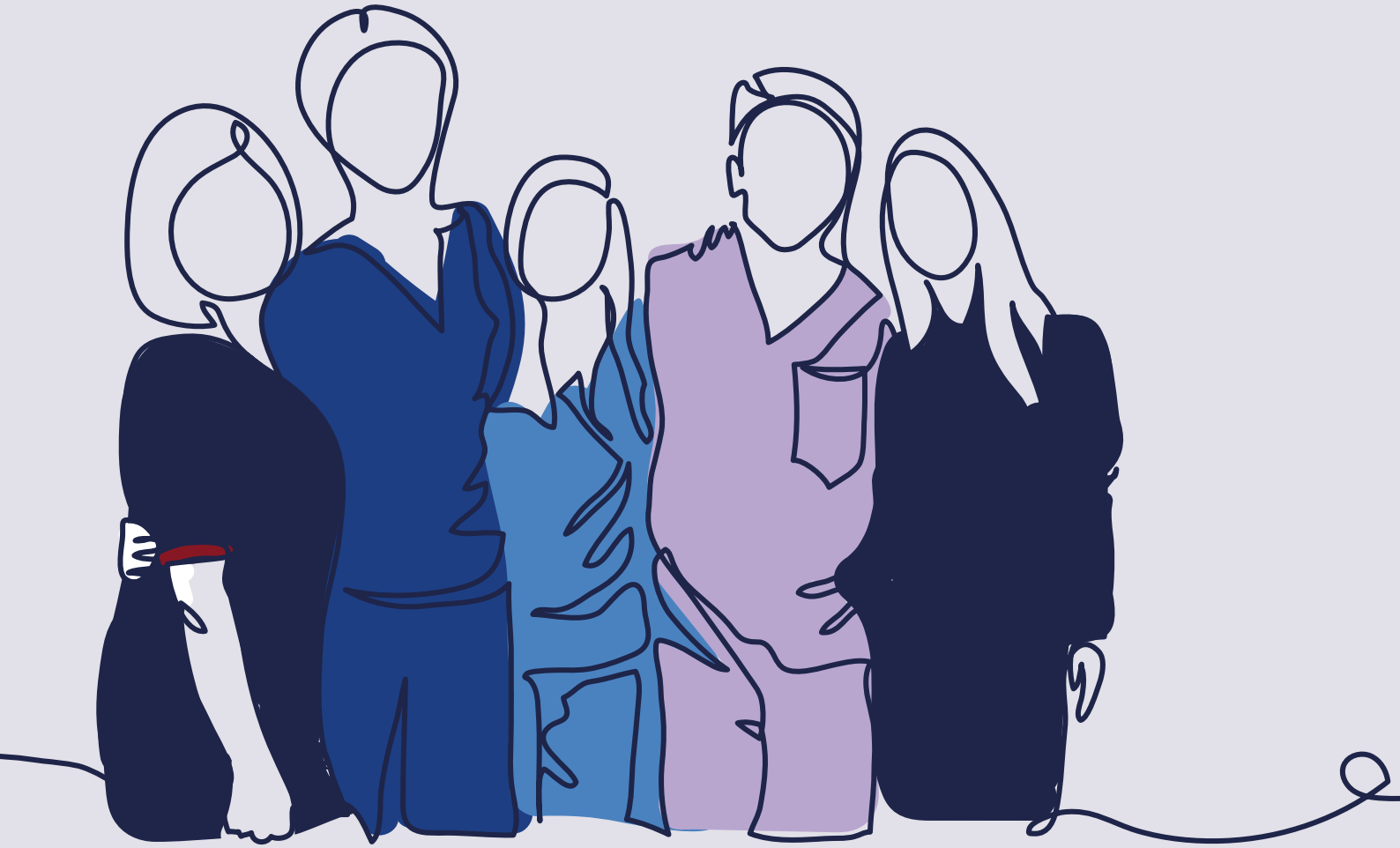
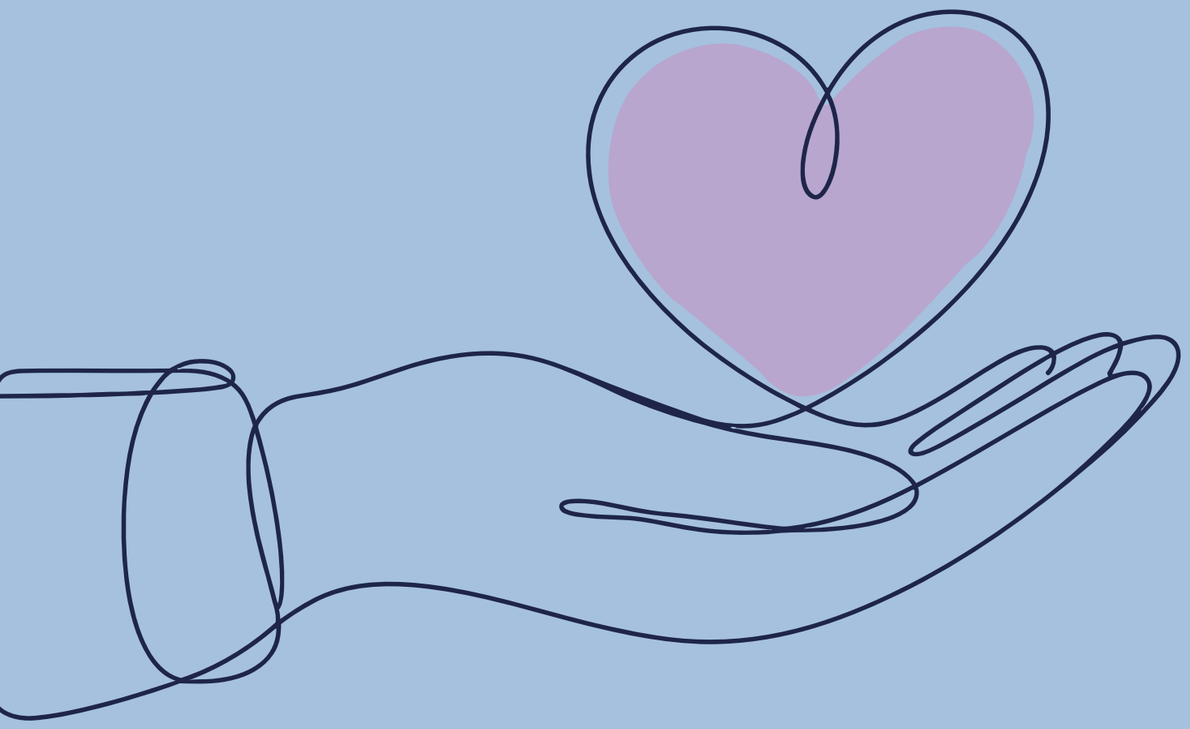
CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Intervention Manual

Evidence-Based Nurse-Led Hospital Based Violence Intervention Programmes





Foreword

Tackling violence in all its forms remains one of the most urgent responsibilities that we share as public services, communities and partners across South Wales and UK-wide.

Within my Police, Crime and Justice Plan (2025-29), I set out a clear commitment to prevent harm, protect the vulnerable and work tirelessly to reduce the devastating impact that violence has on individuals, families, communities and services.

This manual reflects that commitment in action. It provides a guide to a collaborative approach that can transform the way we respond to those who come through our emergency departments as victims of violence, drawing learning from evidence-based and evaluated interventions in South Wales.

The introduction of nurse-led Violence Prevention Teams (VPTs) represents a significant step forward towards achieving the UK Government's Serious Violence Duty. This Duty requires us to work collectively across policing, health, local authorities and wider partners, to understand the causes of serious violence and to support early intervention. Through identifying vulnerability and offering tailored support at a reachable moment, these teams are helping to break the cycle of harm before violence escalates further.

I am immensely proud that funding from my office has supported the development and growth of VPTs, and the success is also testament to the dedication and passion of nurses, caseworkers, the many statutory and third-sector partners who stand alongside them and the health boards that have enthusiastically adopted the approach. Their efforts have already delivered measurable improvements, reducing repeat emergency department attendances, improving safeguarding and ensuring that more people feel seen, heard and supported at moments of crisis. These VPTs are an example of partnership working at its very best.

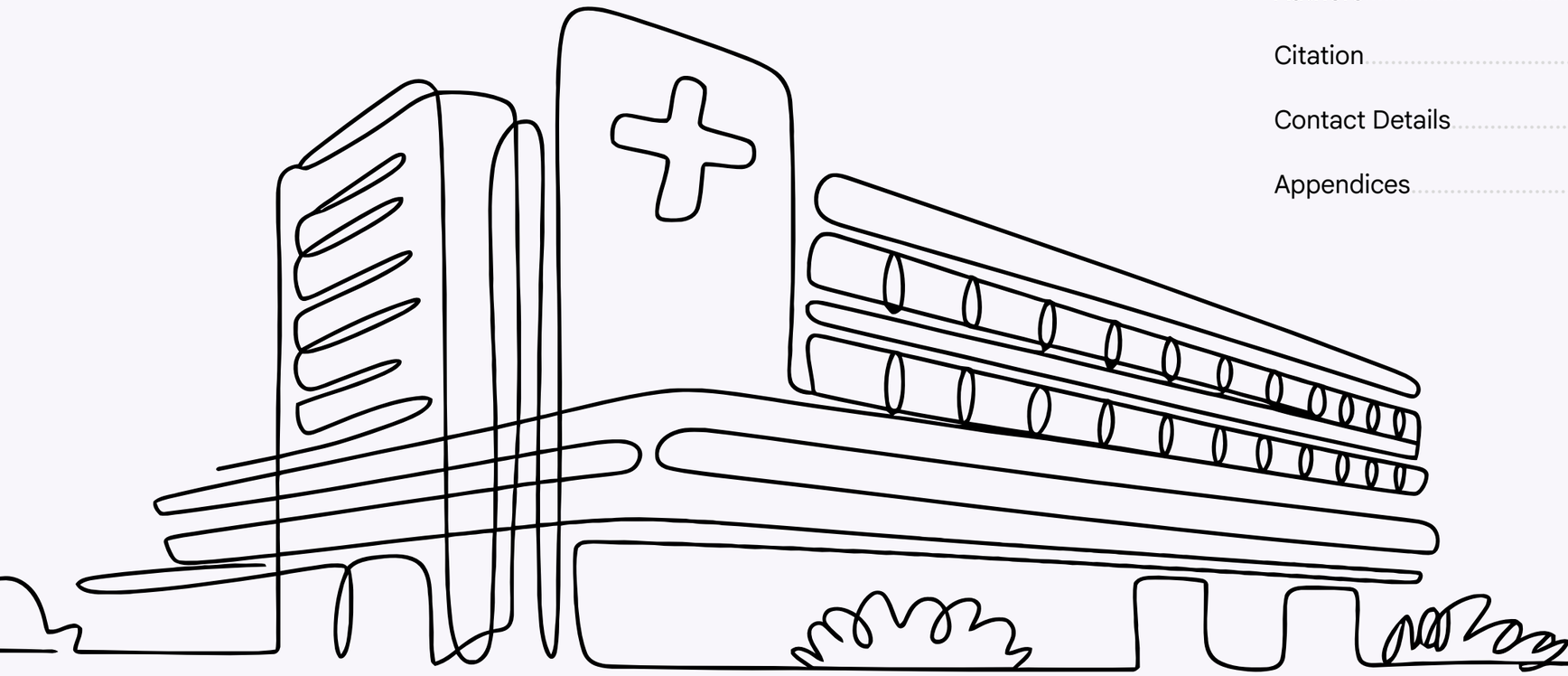
However, we know there is more to do, and violence continues to devastate too many lives. The work outlined in this manual strengthens our collective ability to respond to these challenges, and how health and policing can work hand in hand to respond not just to a single incident, but to address the underlying factors that place people at risk of involvement in violence.

Our commitment as specified authorities under the Serious Violence Duty must remain unwavering, and we must continue to invest in approaches that are proven to work; challenge ourselves to do better; and ensure that every intervention contributes to safer, stronger and more resilient communities.

I am grateful to all those who have contributed to this manual and to the ongoing delivery of VPTs. I hope that this manual will not only strengthen work already underway but also support the expansion of VPTs across South Wales and further afield, so that all communities are able to benefit from this proven approach.

Emma Wools

South Wales Police and Crime Commissioner



Intervention Manual

Contents

Introduction

The purpose of this manual is to describe the nurse-led Hospital Violence Intervention Programmes, implemented and evaluated in Wales, UK.

This manual therefore supports health care professionals, health boards, and statutory services in planning, designing, implementing, and delivering Hospital Violence Intervention Programmes, known as Violence Prevention Teams (VPTs).

Nurse-led VPTs provide support to patients with modifiable risks and psychosocial vulnerabilities who attend Emergency Departments (EDs) due to violence. Patients are referred into the VPTs by the ED clinical team or are identified by VPT staff who review clinical records and conduct floor rounds. Patients are then, as needed, referred by the VPTs to NHS, statutory, or third-sector services for additional support. The VPTs can also hold cases to provide ongoing support to patients as they transition across services.

An effectiveness and cost-effectiveness evaluation of VPTs found that, compared with usual care, VPTs reduce subsequent ED attendances, and are cost-effective from an NHS and societal perspective. VPTs further overcome barriers faced by patients in disclosing that their attendance in the ED was due to violence, therefore addressing healthcare inequality. Those who are less likely to disclose their attendance was associated with violence are more likely to be young, male, from a minority ethnic group and reside in more deprived neighbourhoods.

This manual was developed through a collaboration between Cardiff University (the Violence Research Group and DECIPHer), the Office of Police and Crime Commissioner for South Wales, and the VPT staff. The work was funded by the National Institute for Health and Social Care Research Public Health Board (NIHR134055), and the Youth Endowment Fund (LGR1-EVAL-032211). Any views expressed in this manual are those of the authors and not necessarily those of the NIHR, the Department of Health and Social Care or the Youth Endowment Fund.

A Case for Emergency Department-led Violence Prevention

Violence is both a national and global public health issue affecting individuals, communities, and broader society, and it impacts services, including healthcare[1].

The case for violence prevention initiatives is clear:

Violence causes decreased well-being and premature mortality[2].

Young people (aged 16-24 years) are more likely to be victims of violence than older age groups[3].

In the year ending March 2024, there were 570 victims of homicide in England and Wales, with teens more likely to be killed by a knife (or other sharp instrument) compared to other age groups[4].

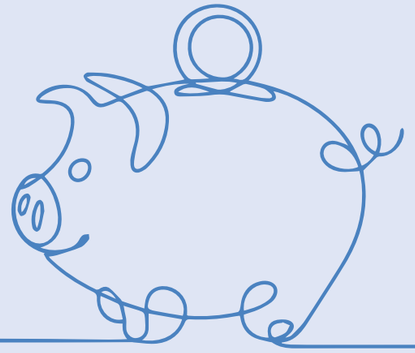
Violence against women and girls, domestic abuse and sexual violence (VAWDASV) affected approximately 2.3 million people in England and Wales in the year ending March 2024. VAWDASV is often perpetrated by men on women[5,6].

Addressing violence is a UK Government policy priority. The UK Government enacted the Crime and Disorder Act (1998) and, subsequently, the Serious Violence Duty (2022) to promote multi-agency working between the police, local authorities, youth offending services, and the health service to reduce serious violence[7,8].

The Serious Violence Duty also required local authorities and services to share information and data and to develop evidence-based interventions to reduce violence[8]. To promote the multi-agency approach, the UK government allocated funds to establish Violence Reduction Units in England and the Violence Prevention Unit in Wales.

The Violence Prevention Teams

Home Office Grant funding was received by the South Wales Police and Crime Commissioner.



This funding enabled the Violence Prevention Unit in Wales to support the development and implementation of a VPT in the University Hospital of Wales, Cardiff and Vale University Health Board in November 2019 following previous work around the link between vulnerability and crime. During January 2022, through funding secured from the Home Office and the Youth Endowment Fund, learning was taken from the Cardiff VPT Model to develop a similar model in Swansea Bay University Health Board, Morriston Hospital.

The VPTs operate according to a public health approach to violence: violence is preventable, and social determinants and modifiable risk factors are linked to an increased exposure to violence[9]. Interventions should therefore focus on these risk factors. The VPTs aim to support those exposed to violence and, in discharge planning, referring patients into support according to need. The VPTs also provide tailored one-to-one support.

Further details of the VPT model can be found in the appendix (Appendix 1).

Effectiveness and Cost-Effectiveness

We undertook an effectiveness and cost-effectiveness evaluation that compared patients receiving support from the VPTs with matched controls, and an Implementation and Process Evaluation (see Related Research).

The results from this work found:

- VPTs are cost-effective. When all social, primary, and secondary healthcare costs are included, VPTs are shown to be cost saving to the NHS.
- VPTs are effective. Patients who engage with the VPTs are less likely to reattend ED.
- The VPTs identified more patients attending due to violence compared to usual care. Patients who were reluctant to disclose under usual care but were identified by the VPTs were typically male, young, from black and mixed ethnic groups and residing in the most deprived areas.
- Stakeholders across the violence-prevention ecology regarded the VPTs as essential for violence prevention in the health setting.

Implementation

When planning the implementation of a VPT within an ED, health boards may first wish to consider how the model can be adapted to local population needs and workforce capacity. Early decisions might include whether the service should replicate a nurse-led structure, incorporate existing advocate / safeguarding roles or a blend of the two.

The first VPT, implemented at Cardiff's UHW, was designed based on the evidence-based Independent Domestic Violence Advocate (IDVA) model that had been successfully established and delivered within the health board. Adopting a public health, whole-system approach.

The original aims of the VPTs were to:

- Deliver specialist support, advice, and guidance.
- Engage those with knife injuries, involved in drug crime, and who were 25 years of age or younger.
- Promote desistance from knife crime and drug involvement through encouraging wider support with interventions and related services.

These aims were adapted to advance equitable healthcare and meet the support needs of healthcare staff:

- All types of violence were included (including violent self-injury). This excludes sexual and domestic violence that are supported by IDVAs and Independent Sexual Violence Advocates (ISVAs) within the wider health board team or through external IDVA, ISVA and Sexual Assault Referral Centres.
- The inclusion of all patients over 11 years of age.

Implementation remained adaptable, with ongoing emphasis on understanding and adapting the service to context-specific factors such as patient populations, unique ED internal contexts, and local referral opportunities. For example, an increase in school-based violence meant additional referral options to School Nurses was required.

Initial Set-up

Before establishing a new VPT, health boards should consider planning practical infrastructure requirements, for example where the team will be physically situated, how staff will identify eligible patients and what introductory engagement is needed to build trust and awareness across clinical teams.

In Cardiff and Swansea, initial set up was aided by:

- Early engagement with ED staff and hospital staff. This was enabled through ward rounds, face-to-face meetings with staff, and the provision of training to existing, new and agency staff.
- Having a fixed, physical location in the ED that enabled impromptu consultations with the clinical team.
- Finding the least resource intensive method of referral for the clinical team.
- An understanding of the factors promoting violence in the ED catchment area, and the referral options available for patients.

Staffing and Management Structure

Governance

To ensure safe and efficient delivery, health boards should consider how the VPT will align with existing governance systems, including safeguarding oversight, data sharing protocols and relationships with multi-agency partners. These governance arrangements should consider both internal health board governance but also wider governance structures e.g., Local Violence Prevention Boards; with data sharing arrangements in place to support local Serious Violence Strategic Needs Assessments.

In the Cardiff and Swansea model, VPTs are housed within the Nurse Safeguarding Team.

Team Composition

When determining the composition of a VPT, health boards may wish to reflect on the balance of clinical and advocacy expertise more appropriate for their population and hospital setting. Considerations may include whether staff require ED experience, safeguarding experience or specialist knowledge of a particular area (e.g., domestic abuse, exploitation, knife crime). Consideration will also be required as to how many staff are needed to manage anticipated demand.

In Cardiff, the VPT was established to include an ED-advocate and a nurse, whereas Swansea embedded a nurse-led structure. Both VPTs have also benefited from strong links to the third sector, including a third-sector caseworker-advocate working alongside each VPT and able to accept eligible referrals.

At least one nurse experienced with the local ED, preferably with additional support from an advocate with experience of available third-sector provision. Nurse-led VPTs are well positioned to access hospital and community data systems, thereby contributing to a detailed and necessary patient history.

Roles

When developing a VPT, it will be important for health boards to consider how roles and responsibilities may vary between nurses and advocates, third sector caseworkers and wider partners. Clarity will be required around clinical tasks, safeguarding duties and support functions.

Violence Prevention Nurses / ED-advocates responsibilities

- Engaging and working with the patients at times that are clinically appropriate according to immediate treatment needs, and preferably face-to-face while patients are in ED. Data indicate that patients are more likely to engage if met face-to-face.
- Providing ongoing education and training to ED staff, including existing staff, agency staff, trainees and new recruits, on how they can identify and respond to patients, the available referral processes, and on how they can protect themselves and patients in ED.
- Offering needs-based, trauma informed and targeted support for patients with the goal of promoting opportunities to break the cycle of violence.
- Building trust, providing support and guidance by assessing initial risk factors and referring to the VPT advocate where appropriate, or making referrals to other statutory or non-statutory services.
- Assisting with the establishment of multi-agency support for patients to improve the quality of care, support available, and guidance received by professionals. This helps to create clear pathways of referral and addresses fragmentation across services.
- Following discharge, to follow-up (over the phone or available contact method) with patients and ‘check in’ with them.

Violence Prevention third sector caseworker-advocates responsibilities

- Offering needs-based, trauma informed and targeted support for patients with the goal of promoting opportunities to break the cycle of violence, where this is relevant for the specific patient.
- Designing service plans for connecting affected children and young people to counselling, family support, mentoring, substance misuse, employment opportunities, and conflict resolution services. This can include other family members who may also be affected by violence.
- Assisting with the establishment of multi-agency support for patients to improve the quality of care, support available, and guidance received by professionals. This helps to create clear pathways of referral and addresses fragmentation across services.

Experience and Traits

Recruitment decisions for a VPT may require health boards to consider the personal and professional attributes necessary for staff engaging with patients affected by violence. This may include experience within high-pressure clinical environments, confidence in navigating safeguarding systems, risk and needs assessments and an ability to build rapport with individuals in crisis. Individual training needs should also be considered, for example on trauma-informed approaches.

Within Cardiff and Swansea, nurses with ED experience brought established relationships with the clinical team. Advocates contributed expertise in the support and referral of patients and had existing relationships with external partners. Both skillsets enabled early adoption of VPTs in ED. Previous experience and personality traits that were considered important for VPT staff include:

- Previous experience:
  - Nursing, and particularly ED experience
  - Existing knowledge of referral pathways.
- Flexibility to adapt to the changing nature of violence in the locality and to develop appropriate referral networks in response.
- To connect and build trust with patients.
- Non-judgemental.
- Drive and a willingness to engage, communicate and advocate for the VPT with staff across different roles, from junior to senior staff, willingness to be persistent and consistent.

Induction and training for new VPT staff is mainly based on practical work and shadowing experienced staff. Formal training included:

- NHS Safeguarding Training
- Other training as is appropriate to their role such as training in PREVENT, Modern Day Slavery, Organised Crime and County Lines.

Health boards may wish to consider a wider range of training prior to staff commencing their role to optimise the set-up and implementation process of the service within their ED.

Operating Hours

When planning VPT service hours, health boards may wish to consider patterns of violence-related attendances in their ED, available staffing resources and the feasibility of extending coverage beyond standard working hours. While many VPTs begin with weekday provision, local data may highlight opportunities to consider weekend or evening engagement. Regardless of opening hours, a robust process for managing out of hours referrals and following these up will be required. In general, VPTs aim to engage with patients while they are in hospital, providing timely support at vulnerable, “reachable” moments for the patient.

Data Monitoring, Patient Identification, and Referral

Data Monitoring

Health boards may need to consider how local data systems, coding practices and information sharing arrangements will influence the VPTs ability to identify violence-related attendances, and how an understanding of VPT activity over time can be communicated to key partners. Establishing consistent processes early, particularly if an evaluation is planned, can be beneficial.

Access to a broad range of community, ED and hospital data systems is needed to identify patients otherwise missed under usual care. These data monitoring activities can be challenging due to multiple systems, inconsistent coding, and poor data quality.

Ascertainment

Health Boards may consider multiple routes through which ED and hospital staff, and VPT practitioners can identify patients affected by violence, recognising that violence may not be initially disclosed under usual care. The processes implemented should reflect existing clinical workflows, staff capacity and the level of digital integration across systems.

Patients eligible for VPT support may be identified and referred into the VPT by:

- The clinical team
  - In-person
  - Online (e.g., email, text message)
  - Via a sticker system in patient file books.
- VPT staff exploring ED data, patient records and written notes.
- Engagement with the ED clinical team (e.g., ward rounds, informal consultations).
- Shared referral processes (e.g., with Health-based IDVAs) can further improve early identification.

Referrals Out

When planning external pathways, health boards may wish to map the local statutory and third-sector landscape. VPTs work best when supported by clear referral routes that can offer ongoing and targeted support based on identified need.

Typically, patients are referred out to partner service by:

Formal routes, using partner systems and referral forms.

Informal routes, through direct contact.

The aim is to enable seamless healthcare for patients. To achieve this, patient referrals are additionally supported by the VPTs, who have curated relationships with statutory and third sector organisations that can provide support to address a variety of patient need.

This support includes:

- Support, advice, brief interventions, and (if appropriate for the patient) guidance to steer the patient away from further involvement with violence. This can also encourage and motivate patients to gain additional professional support as required. It could also facilitate patients to make necessary changes in their lives to lessen the likelihood that they continue to experience violence.
- Assisting with the establishment of multi-agency support for patients to improve the quality of care, support, and guidance received by professionals.

- Supporting patients as they transition to other services, sharing patient details (with consent) to improve the quality of discharge planning and to ensure external partners are appraised of patient circumstances, as required.

An understanding of partners' processes means tailored referral forms or emails are necessary to meet each partner's requirements. Strong links with partners enable formal referrals, informal discussions about cases, and improve overall service delivery.

An example of partner services is available in Appendix 2

Patient Engagement, Assessment and Support

Engagement

To support effective engagement, health boards may consider how VPTs can build relationships with patients during moments of crisis, while also offering follow-up support options.

Within Cardiff and Swansea, the preferred form of engagement with patients was face-to-face in hospital. This is regarded as the most effective in building rapport, trust and securing patient consent. However, due to shift patterns and the nature of emergency care this is not always feasible. If a patient leaves ED before they can be seen, the VPT contacts them by phone, text, or letter within 72 hours with multiple attempts made. The 72-hour limit is not always workable due to shift patterns and staffing levels.

Follow-up

VPTs will typically follow up with patients where initial contact is unsuccessful. There may also be further follow-up attempts following initial contact if required.

Patient-Centred Approach

VPTs should operate a patient-centred approach. A focus should be placed on patient needs, a need for patients to consent to support, and privacy.

Assessment

When designing assessment processes, health boards may wish to consider the range of vulnerabilities prevalent in their ED population and the systems available to support holistic information gathering.

Assessment Process

VPTs should collect demographic details, assault details, vulnerabilities, health history, and prior service interactions. Appendix 3 includes an example form for referrals into the VPT.

Risk Assessment

VPTs should support a holistic discussion, risk form completion, review of patient records, and system updates. For children and young people, assessments include any prior safeguarding, contact with social services, education referrals and youth justice contact.

Duty to Report

Because there is potentially an immediate risk to the public, there is an expectation that it is in the public interest to report injuries resulting from knives (or other sharp objects) or guns to the police.

Support Actions

The support provided includes signposting to other services, assistance registering with a GP, referrals to primary, secondary and tertiary healthcare, referral to third sector organisations, referral into other statutory services, ongoing support for high-risk or long-wait patients and support to the patient's family if needed.

Minimum Dataset

Health boards may find it useful to establish a minimum dataset that balances comprehensive assessment with local capacity and system functionality. Factors such as ED digital infrastructure, availability of linked records and safeguarding reporting requirements will shape what is feasible.

VPTs will curate patient data in addition to that available in ED patient management systems.

Example of the data collected across Cardiff and Swansea VPTs:

Attendance	Date and time of ED attendance Date and time of initial VPT engagement Admitted into hospital (yes/no) Discharge from ED date and time VPT follow up dates and times Deceased date, if applicable Injuries sustained
Patient Details	Date of birth Sex Ethnicity Address including postcode Unique VPT ID number NHS number
Vulnerabilities	Mental health Substance use Alcohol use Intoxicated at ED attendance Homeless On probation Number of previous ED attendances Other
Referral Forms	MARF completed VA1 completed Other
Notifications	Social worker School nurse Police Probation Family contacted/engaged Other
Engagement with VPT	Yes/No Met face-to-face (yes/no) Supported by VPT
Open with other agencies	Name
Referrals	PREVENT Modern Day Slavery Mental Health GP Alcohol and Drugs IDVA ISVA Immigration Housing Other • Date • Organisation • Details
Incident	Location Location description Weapon involvement Weapon type Reported to police Police number Statement made Intelligence submitted Related to drugs Previous related incident

Information Shared

With the consent of patients, VPTs will share essential patient details to organisations into which patients are referred. These details include patient demographics, contact information, nature of violence, vulnerabilities, risk factors, family context, and links to perpetrators or other victims. This ensures agencies receive complete and accurate information and can provide appropriate support. It could also reduce the likelihood patients are re-traumatised by retelling their experiences. Additionally, VPTs can share anonymised intelligence with partners, including the police, where necessary.

Common Scenarios and Management

The VPTs use a patient-centred approach, engaging holistically to understand each patient's circumstances and build tailored support.

This includes exploring home life, education, relationships, and vulnerabilities. Staff experience helps them know when and how to engage, particularly with challenging or vulnerable populations. Case studies illustrate how this approach supports individuals and families affected by violence.

Patient A:
Assault Outside of Licensed Premises

An individual sustained a head injury after being attacked by a group, leading to serious mobility challenges and poor mental health. They remained in hospital and faced difficulties returning home due to living in a flat above ground level. The VPT visited them on the ward and arranged referrals for victim support and housing assistance, including financial and emotional help. Additional support was provided by a charity supporting those experiencing or at risk of homelessness, with VPTs supplying necessary information and following up to ensure progress. The team continued supporting the patient throughout their hospital stay.

Patient B:
Assault Outside of School

An individual was assaulted by peers near their school after ongoing targeting that had previously been reported. The patient shared details with the VPT, who obtained consent to pass information to the police. Referrals were made to youth support services, safeguarding teams, and health professionals, ensuring both the individual and those involved in the incident were linked to appropriate agencies for support and risk management.

Patient C:
Domestic Incident

An individual was admitted with knife and glass injuries, including a deep wound requiring surgery, after an attack by several assailants. Initially thought random, they later suspected a link to an abusive ex-partner, disclosing a history of physical and emotional abuse and concerns about their child. This led to child protection and MARAC referrals. They also reported poor mental health and fears of homelessness. Multi-agency collaboration between health, police, and housing ensured a safe discharge and victim support referral.

Patient D:
Young Person on Young Person

An adolescent attended the ED after being injured with an air-powered weapon by someone they knew. Already coping with bereavement, their anxiety escalated, leading to school refusal, isolation, and disengagement from support. Previous mental health involvement had ended due to non-engagement, and parents disclosed past self-harm concerns. The VPT coordinated referrals to mental health and youth services, overcoming barriers in the process. With renewed engagement, the young person began attending school and participating in support programmes, with the family reporting significant improvement thanks to multi-agency collaboration and persistent follow-up.

Support for VPT Staff

When establishing a new VPT, health boards should consider how to support wellbeing of staff, supervision processes and resilience, recognising the emotionally demanding nature of violence-related work.

Local safeguarding teams, psychology services or peer networks may play different roles depending on health board structures.

Within Cardiff and Swansea, support offered to VPT staff includes:

- One-to-one supervision with line managers.
- The ability to call line managers if extra support is needed.
- More informal methods of supporting wellbeing. Some VPT staff suggested that, due to team working, other VPTs and teams in ED, such as Health-based IDVAs, can provide additional support.

Manging Risk to VPT Staff

Health boards should consider how best to manage practitioner safety within busy emergency settings, balancing accessibility to patients with safe working environments. The VPTs often talk to patients in private. To ensure their safety, the VPTs in Cardiff and Swansea:

- Ensure they sit next to the door in the case that they need to leave the room.
- Check patient notes to see if patient has a history of being violent.
- Can be joined by another colleague or inform another colleague of risk.

As the VPTs are typically situated in or near the ED, nurses could reach out for additional help from other staff. However, to date, they have not had a situation where they have felt at risk. Health Boards should consider if there are additional measures to their existing ED's practice that should be implemented.

Related Research

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Authors

This resource was developed by Megan Hamilton, Jordan Van Godwin, and Professor Simon Moore at Cardiff University, in collaboration with members of the South Wales Police and Crime Commissioner's Office. Members of the Violence Prevention Team shared information about the service, and we thank them for their contribution.

The Violence Prevention Teams were developed and implemented in Wales; however, the content of this intervention manual can inform service development in England, Scotland, and Northern Ireland.

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Appendices

Appendix 1: TIDieR

The Template for Intervention Description and Replication (TIDieR) [S1] is used to describe the HVIPs evaluated, which was adapted from a formative evaluation of the Cardiff Violence Prevention Team [S2].

Brief Name

Violence Prevention Team (VPT)

Preparation of TIDieR

Preparation of **TIDieR** was undertaken by

- Cardiff University (Violence Research Group and DECIPHer)
- Youth Endowment Fund (YEF), who also part-funded the intervention and funded the process and implementation evaluation.
- An expert advisory group provided oversight, including experts from Public Health Wales, Welsh Trauma Network, South Wales Police, Office of the Police and Crime Commissioner, and third sector organisations including Welsh Women's Aid, The Wallich and Black Association of Women Step Out (BAWSO).

Service Delivery

- VPT staff (nurse, nurse advocate, community youth workers), who implemented and continually developed the service.
- Clinical teams in the two Emergency Departments (EDs) in which the interventions are situated provide clinical governance.

Commissioners

- Wales VPU (partner agencies including South Wales Police Office for the Police and Crime Commissioner), and Public Health Wales), provided the bulk of the funding for the interventions and have on-going dialogues regarding the service development, implementation, and delivery at both implementation sites.
- The UK Home Office provided initial funding to the VPU and YEF.

Intervention Need

EDs receive for treatment patients who have been exposed to violence. There are numerous reasons why some people are exposed to violence, including their alcohol use, illicit drug use, unstable or chaotic homelife, amongst other reasons. These vulnerabilities will also be associated with increased utilisation of emergency care generally. EDs therefore have a unique opportunity to offer these patients additional support, beyond treatment for acute health needs, either directly or through referral to other healthcare services, or in discharge planning signposting third-sector organisations, for example. If this support is successful, then the expectation is that patients will exhibit a reduced use of emergency care services in general, not just for violence-related injury.

The primary objectives of the hospital-based service provision are to

i. identify patients attending EDs whose attendance is predicated on their exposure to violence,

ii. work with patients to understand any circumstances or vulnerabilities that increase their exposure to violence, and (iii) to either support their referral into secondary or third-sector care or to provide ongoing case-management alongside third-sector support.

All patient-facing clinical staff in emergency care, and elsewhere, have a duty of care and will have received training necessary to undertake patient safeguarding. However, the additional resources involved with the VPT afford

i. greater time working with patients to determine need,

ii. deepen links with primary, secondary, and tertiary care, and third sector organisations, for improved referral processes,

iii. work across clinical teams to support colleagues with their safeguarding needs and referral into the intervention, and

iv. through direct contact with patients, support opportunities for disclosure and therefore increase ascertainment of assault-related attendances.

While the VPT can and will refer to any community service provider based on patient need, specific funding has been dedicated to two different organisations where the VPTs are located. The community-based provision provides intensive support to high-risk children and young people (aged 11-24 years) involved in serious organised crime, drug-related activity, and showing signs of exploitation. The objective is to build resilience to enable these young people to be diverted away from further involvement in serious violence and organised crime.

Physical or Informational Materials Used in the Intervention.

The VPTs have made resources available to patients and their families, including leaflets providing details of the service, and information packs to inform them of key issues (e.g., county lines and exploitation).

The VPT has available physical and informational materials usually available to ED staff. This includes access to patient records, both specific to the ED and community healthcare generally. This information facilitates risk assessment and safeguarding practices (e.g., identify patterns of attendance at health care settings for violent-related injury), as well as allowing the VPT to ensure their engagement with patients is appropriate at that time (with consideration to the patient's clinical needs).

In addition, the VPT have strong links with South Wales Police, and receive information and intelligence relating to violence related incidents and community problems. The provision of this information and intelligence to the intervention teams can help inform their interactions with patients and ensure the safety of the hospital and patients (e.g., in cases of youth violence where further attempts to harm a patient may occur).

The VPT provide training to a wide range of clinical and non-clinical staff within the hospital, including

- Clinical hospital staff, on violence (e.g., youth violence) and vulnerability, identifying violence-related injury and engaging with patients, implementing safeguarding procedures for violence-related injuries (e.g., completing multi-agency referral forms, MARFs).
- Reception staff, on data entry and patient coding, to improve the quality of routine clinical data.
- The nature of medical education entails short-term postgraduate and speciality training, and therefore a steady flow of clinical staff new to the ED environment. The VPT provides education and training, and impromptu advice and support through one-on-one interactions, to hospital staff. This includes providing consultation on patients and facilitating patient interactions for more challenging cases.

The procedures, activities, and/or processes used in the intervention, including any enabling or support activities.

The VPT engages with patients at different stages of their journey, depending on the type and severity of their injuries, the time and day they attend the ED, and the longevity of their hospital stay. They are embedded in the ED clinical team, and have the same resources (e.g., access to electronic patient management systems) as other ED staff.

Referrals: The VPT can receive patient referrals through multiple channels, including email, phone, and face-to-face contact. During their shift, VPT staff can be notified of eligible patients through a set of questions asked during patient registration, triage or by monitoring the ED patient management system. When the VPT is not on shift, paper-based referral forms are available, and staff can still use formats to refer patients and the VPT will retrospectively review the ED patient management system to identify any additional patients that may have been missed by clinical staff.

Processes: The VPT provides individualised support to patients based on their needs and collaborates with primary, secondary and tertiary care, third sector organisations and other statutory organisations (e.g., local government safeguarding teams, the police, and school nurses). They establish a relationship with the patient and, where appropriate, their family. They provide emotional and practical support. They also manage vulnerabilities and risks to patients by gathering information and through collaborative multiagency work. This can be through existing resources, such as the Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) tool, and referrals into the Multi Agency Risk Assessment Committee (MARAC).

The VPT will either discharge patients to receive support elsewhere, or, in the case of high risk, high need children exposed to criminal or sexual exploitation, continue their support of the patient alongside third sector organisations specifically funded to support the VPT in this area.

Access to Information

The VPT has access to usual healthcare patient management systems, both ED specific and community-based, that can be accessed to inform patient assessments and safeguarding decisions.

Furthermore, the VPT access information on patients to inform risk assessment and management. For example, following incidents of serious violence (e.g., stabbings and shootings), they will gather information on risks and known associations through the police, VPU team (i.e., police and probation), hospital staff, and through the safeguarding team (who routinely meet to discuss patients).

Assessment

The VPT completes a risk- and needs-based assessment in collaboration with patients if they agree to engage and, where appropriate, their families. This will also include information obtained through patient records (e.g., PARIS and clinical portal) on previous hospital visit.

Expertise, Background and any Specific Training Given to Each Intervention Provider.

VPT staff will be trained to Level 2 or Level 3 Safeguarding, available through continuing professional development to all frontline staff in the NHS. VPT staff are typically seconded from the broader ED team and will typically be nurse-led.

Additional third-sector support is funded to provide support to high risk, high need children.

Modes of Delivery

The VPT team meets with patients face-to-face in the ED if they are on shift, or on hospital wards if the patient is admitted. If the team is not on shift, or receive referrals from Minor Injury Units, they will follow-up with a phone call and conduct an assessment. All contact is done on an individual basis, or in collaboration with the family (for under 16-year-olds, or in cases the patient consents to family involvement).

Under usual safeguarding processes, the clinician who first receives any disclosure is expected to lead on the subsequent referral to the VPT, so that patients are not required to repeatedly describe circumstances they might find distressing. In this latter case, the VPT will support the patient's referral.

Location of the Intervention

The VPT are physically based in the ED. However, they can accept referrals from Minor Injury Units and also provide support to patients on the wards if they are admitted following serious injury. The VPT also work with patients that are transferred from other health care facilities- which is particularly pertinent when the hospital is a major trauma centre, or trauma unit, and therefore accepts out-of-area patients. The VPT engage with other health care settings to facilitate transfers (e.g., provide information on known risks and vulnerabilities), and inform care planning.

Intervention delivery, number of sessions, schedule, duration, intensity, and dose.

Patients will either engage with the VPT or will refuse support. If the latter, they will have been in contact with the VPT once. For patients who engage with the VPT, the frequency and duration of engagement with patients will be determined through the patient's age, clinical need, and any underlying vulnerability.

Hospital-based VPT

The VPT typically have one or two interactions with most patients, such as a phone call or text message. However, patients with greater needs may have more frequent contact and remain on the caseload for several weeks. Inpatients are supported until they are discharged. The VPT can only maintain a small caseload of patients who require longer-term support, typically those on waiting lists or who are too vulnerable to disengage with. Patients referred to the caseworker have minimal involvement with hospital-based services.

Caseworker

The caseworker offers high-intensity support for high-risk, high-need young people and engages with them two to three times a week. To maintain this level of contact, the caseload is limited to five young people at a time. Some service users may be on the caseload for an extended period if they resist engagement. However, for patients referred to hospital-based services, the caseworker has minimal involvement or contact.

Intervention Tailoring

Level of Harm

The VPT engages with patients attending ED in consequence of their exposure to violence. All patients are eligible and initial assessment will determine how patients are managed. In the case of domestic abuse, the patient will be handed over to an Independent Domestic Violence Advocate (IDVA). In the case of sexual abuse, the patient will be handed over to the Independent Sexual Abuse Advocate or the Sexual Assault Referral Clinic. In the case of self-harm, the patients will be handed over Mental Health Services. The VPT will therefore typically engage with patients attending with non-domestic violence-related injuries, of varying acuity. The team offers immediate support to patients with non-life-threatening injuries, while for high acuity patients, they wait until the patient is stable before offering their services. The VPT team conducts assessments for patients admitted into the hospital, which allows them to provide more intensive support.

Caseworker

The caseworker engages with patients either in the hospital or in community settings and maintains a caseload of up to five young people at a time for high intensity support.

Stage of Implementation

This is an initial TIDieR, generic to two sites at which the VPT model has been implemented. The VPTs at the two sites are at different stages of implementation with one having a significantly longer operational period.

Assessment of Intervention Fidelity

The VPT model is subject to a formal evaluation, and a process and implementation evaluation, which this TIDieR informs. The outcome from these evaluations will be a revised logic model, an understanding of the adaptations made to the intervention based on locality, and a formal effectiveness and cost-effectiveness evaluation.

Actual Intervention Fidelity

Delivery of the intervention has been impacted by staffing changes in both sites, with both sites operating with reduced staff during periods of their operation. As a result, this has led to delays engaging with and referring some patients for further support.

References

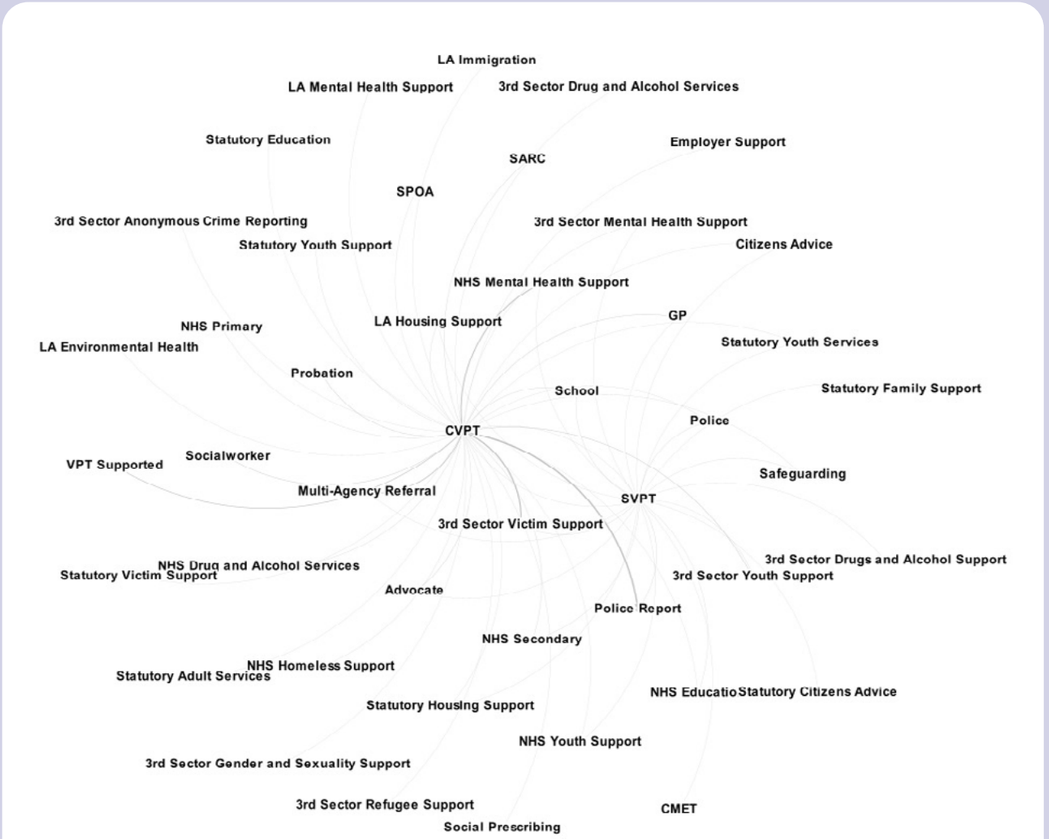
[S1] Hoffmann T, Glasziou P, Boutron I, Milne R, Perera R, Moher D, Altman D, Barbour V, Macdonald H, Johnston M, Lamb S, Dixon-Woods M, McCulloch P, Wyatt J, Chan A, Michie S. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ. 2014;348:g1687.

[S2] Newbury A. A service evaluation of the delivery and implementation of a hospital-based Violence Prevention Team within the University Hospital of Wales. Public Health Wales. Accessed June 5, 2024, https://www.violencepreventionwales.co.uk/cms-assets/research/A-Service-Evaluation-of-the-Delivery-and-Implementation-of-a-Hospital-Based-Violence-Prevention-Team-within-the-University-Ho.pdf

Appendix 2: Referral Pathways

The VPTs recorded the immediate destination of patients referred into statutory and third sector services. These referrals are depicted in the network chart in figure S1, showing the Cardiff VPT (CVPT) and Swansea VPT (SVPT). Further information for each destination is provided in table S1. These referral networks will be unique to each ED catchment.

Figure S1 – VPT referral network. CVPT – Cardiff Violence Prevention Team; SVPT Swansea Violence Prevention Team



Over time, the Violence Prevention Teams curated extensive referral networks through which they were able to refer patients for additional support.

Table S1 – Description of nodes depicted in figure S1

Label	Description
CVPT	Cardiff Violence Prevention Team
SVPT	Swansea Violence Prevention Team
LA immigration	Immigration support from local authorities. Such as, housing given by local councils.
LA Mental Health Support	Mental health support given from local authorities. Such as, community mental health teams.
3rd Sector Drug and Alcohol Services	Drug and alcohol support given by third sector/ charities. Such as, NEWID drug and alcohol support and BAROD.
Statutory Education	Education experiences such as TAITH (International exchange programme).
Employer Support	Employee wellbeing services, such as the People Health and Wellbeing Service by Cardiff and Vale Health Board for their employees.
SARC	Sexual Assault Referral Centres. Supporting those who have experienced sexual assault.
SPOA	Single point of access. An NHS system where there is a single point of contact where patients can have a clinical assessment by a multidisciplinary team. Patients can be referred on or cases can be held.
3rd Sector Anonymous Crime Reporting	Online anonymous crime reporting led by Crime Stoppers. CYP service called Fearless.
3rd Sector Mental Health Support	Mental Health support led by third sector organisations such as, MIND, the Amber Project, The Samaritans, Concern Cymru and PLATFFORM.
Statutory Youth Support	Support from statutory bodies and local authorities such as, Councils Children's Care Services and Youth services like Cardiff and Vale Early Help Services and Cardiff and Vale Young Wellbeing.
Citizens Advice	A UK-based organisation aiding people with legal, housing, debt and other services.
NHS Mental Health Support	Mental Health support given by NHS organisations, such as Children and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Support Services and Mental Health Liaison Nurses.
NHS Primary	Primary care, e.g. GPs, pharmacies, dentists and opticians.
LA housing support	Housing support given by local authorities such as, houses given by councils, tenancy support units and LA/council-based homelessness support.
GP	General practitioner.

Statutory Youth Services	Local Government support for young people.
Local Authority Environmental Health	Public health inspectors who ensure health and safety is upheld in the workplace.
Probation	Probation Services supporting those who are on probation.
School	Letting schools know about support or support from school nurses.
Statutory Family Support	LA/council-based family services.
CVPT	Cardiff Violence Prevention Team. They can refer onto the focused agencies, or they can hold cases.
Police	Police reporting with consent, police support, police services and in cases where a weapon is used non-consensual police reporting.
Social Worker	Individuals that can provide support and safeguarding to vulnerable people.
VPT Supported	Support given to patients and cases held.
Safeguarding	Statutory/LA safeguarding, such as council-based safeguarding for example, educational safeguarding.
Swansea VPT	Swansea Violence Prevention Team. They can refer onto the focused agencies, or they can hold cases.
Multi-agency Referrals	Multi-agency referrals and forms, such as, referral into a multi-agency risk assessment conference (MARAC).
3rd Sector Victim Support	3rd sector support for violence-related attendances including domestic violence services. Such as, Victim Focus/ Support, New Pathways and St Giles.
NHS Drugs and Alcohol	Drug and alcohol services led by NHS. Such as, Cardiff and Vale drugs and alcohol services (CAVDAS).
3rd Sector Drug and Support	3rd sector support and treatment for drug-related issues.
3rd Sector Youth Support	3rd sector support for children and young people. Such as, Media Academy Cymru and Action for Children.
Statutory Victim Support	Support for victims led by LA/statutory bodies. Such as, council-based support for domestic violence.
Advocate	Independent domestic violence advocates (IDVAs) and independent sexual violence advocates (ISVAs).
Police Report	Consensual police reporting or non-consensual police reporting if a weapon was used.
NHS Secondary	Hospital and community care. Such as, outpatient services.
NHS Homeless Support	NHS based support for homelessness. Such as, the Cardiff and Vale Homeless Nursing Team.
Statutory Adult Services	LA/statutory support for adults.

NHS Youth Support	NHS based support for children and young people. Such as, Cardiff and Vale UHB Early Help Services and young people's/paediatric IDVAs.
3rd Sector Gender and Sexuality Support	Gender and sexuality support led by 3rd sector organisations. Such as, Umbrella Cymru's Gender and Sexual Diversity Support Specialists.
3rd Sector Refugee Support	Support for refugees and asylum seekers. Such as, Oasis.
Social Prescribing	Support via community activities based on what the patient enjoys. Such as, boxing and football clubs or gaming.
CMET	Contextual, Missing, Exploited and Trafficked. A multi-agency panel for safeguarding.
IRF	Inpatient Referral Facility, Facilities with acute care services. May be for drugs and alcohol or mental health.

Appendix 3: Cardiff & Vale UHB NHS Violence Prevention Referral Form

This assessment form is to be used to identify victims who are suspected of any violence related injury. Please complete each section fully.

To be completed by professional:	Yes	No
Do you suspect the injury has been caused by a Knife or sharp instrument?		
Has the patient disclosed any violence relating to their injury?		
Do you suspect drugs to be involved in this admission?		
Do you have any concerns that the patient may be at risk of exploitation?		
A knife related incident must be reported to police. Please document the police reference number:		
If incident is knife related, did you inform security?		
Any patient passwords:		

Additional Information - Details of presentation e.g. injuries, disclosure made etc.	
Date of attendance:	Time of attendance:

Perpetrator Personal Details if known - please list if there are multiple perpetrators			

Does the patient have any children?			
Name	D.O.B	Address	Parental Responsibility
			Yes / No
			Yes / No
			Yes / No
			Yes / No

If the patient is involved with anyone under the age of 18 a Multi-Agency child protection (MARF) referral must be completed.

Patient Demographics

Gender	
Age	
Ethnicity	
Local Authority	
School / Employment	

Do you consent to be contacted by the Violence Prevention Team?

If yes please sign below and provide a suitable contact number:
(If patient is under the age of 18 this document needs to be co-signed by a responsible adult.)

Patient/Responsible Adult Signature: **Contact Number:**

....

....

Name and designation of staff member completing this form:

Signed .....

Date .....

Print name .....

Job Title .....

Ward/Department .....

Phone Number .....

Appendix 4: Glossary

HVIP	Hospital-based Violence Intervention Programme
VPT	Violence Prevention Team
VPRU	Violence Prevention Reduction Unit
VRU	Violence Reduction Unit
A&E	Emergency Department
NHS	National Health Service
SVD	Serious Violence Duty
CJS	Criminal Justice System
ARA	Assault-related attendance
UHW	University Hospital of Wales
SBUHB	Swansea Bay University Health Board
CAVUHB	Cardiff and Vale University Health Board
AfC	Action for Children
MAC	Media Academy Cymru
SW	South Wales
IDVA	Independent Domestic Violence Advocate
DA	Domestic Abuse
SV	Sexual Violence
VAWDASV	Violence Against Women (and Girls), Domestic Abuse and Sexual Violence
SARC	Sexual Assault Referral Centre
CMET	Contextual, Missing, Exploited and Trafficked

Comisiynydd yr Heddlu a Throseddu De Cymru
South Wales Police and Crime Commissioner

GIG CYMRU NHS WALES

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

The purpose of this manual is to describe the nurse-led Hospital Violence Intervention Programmes, implemented and evaluated in Wales, UK.