SOCIAL FINANCE

VRU | MAYOR OF LONDON

Shifting Systems to Embed and Sustain Hospital-Based Youth Work

July 2025

Contents

About this report, and acknowledgements

The London Violence Reduction Unit (VRU) funds the Hospital-Based Youth Work (HBYW) programme, which places trained, specialist youth workers in A&E departments and Major Trauma Centres (MTCs) to support young people during moments of acute crisis. These commissioned services are delivered across 12 sites by three youth work providers: St. Giles Trust, Oasis Youth Service and Catch22's Redthread services.

Based in A&E services:

- Newham University Hospital
- Queen Elizabeth Hospital
- Croydon University Hospital
- University Hospital Lewisham
- Whittington Hospital
- North Middlesex Hospital
- St Thomas' Hospital
- Homerton University Hospital

Based in Major Trauma Centres:

- Kings College Hospital
- St George's Hospital
- St Mary's Hospital
- The Royal London Hospital

Social Finance was commissioned as a Learning Partner to the London VRU and the three youth work providers from October 2023 to June 2025. This paper is a final output of that partnership, developed alongside the *Delivering Hospital-Based Youth Work Guide*, which summarises good practice. Drawing on workshops, data reviews, and cross-sector engagement, it outlines how HBYW can be better embedded and sustained within the systems it operates in. It identifies the underlying systemic root issues limiting integration and offers eleven practical recommendations to embed HBYW more fully into local and national systems. Applying a systems change lens, it complements existing guidance with the intention of making HBYW a vital part of support for young people impacted by violence. While grounded in London's context, the insights have broader relevance.

Authors and acknowledgments

The paper has been written by **Veniecia Laylor** (Associate, Social Finance) and **Tanveer Sian** (Associate Director, Social Finance).

We are grateful to **Lennina Ofori**, systems change consultant and founder of the Awareness TAP, who was a consultant on this project and whose systems, ethnographic research, and storytelling expertise helped frame this work in a way that honours lived experience and challenges structural barriers with clarity.

Thank you to the **youth work providers – St Giles Trust, Oasis Youth Service, and Catch22's Redthread –** for their insight, openness, and patience throughout 18 months of collaboration, and their commitment to delivering a service that gives vulnerable young people such valuable support.

We appreciate the **London VRU** for their commitment to learning and their strategic focus on creating the system conditions needed for a more embedded and sustainable HBYW service.

Thanks also to the **external roundtable participants** – **including representatives from ICBs, NHS trusts, social work, the voluntary and community sector, and the Metropolitan Police** – whose cross-sector insights sharpened our understanding of what meaningful integration requires.

Finally, to the hospital-based youth work practitioners who shared your frontline experiences: your honesty, thoughtfulness, and commitment shaped this work. We hope this paper reflects the realities you face and honours the essential work you do every day with some of the most vulnerable and marginalised young people in our communities.

Defining Hospital-Based Youth Work and Why Systems Change is Needed

Hospital-based youth work (HBYW) places trained, specialist youth workers in A&E departments and Major Trauma Centres (MTCs) to support young people at moments of acute crisis – most often after incidents of serious violence. It centres on the idea of the reachable moment: the period following a traumatic event when a young person may be more open to support and more willing to engage with someone who understands their world and offers a non-judgemental way forward.

Since its early development in the UK in the mid-2000s, hospital-based youth work has become a recognised and valued intervention for young people affected by violence. The model offers trauma-informed, relational support to young people who might otherwise fall through the cracks – those who distrust statutory services, or who face multiple barriers to safety, stability and opportunity. When young people are hurt, scared, angry or overwhelmed, practitioners offer a consistent, compassionate presence – helping them navigate systems that are often impersonal, complex, and ill-equipped to meet their needs.

Practitioners often combine lived experience with cultural competence, trauma awareness and system navigation. They engage young people in ways few others can, but while its impact at the individual level can be transformative, hospital-based youth work is still too often on the margins of the systems it operates within. Delivery depends heavily on trusted relationships and local champions. Recognition and access vary significantly from site to site. Practitioners' ability to do their jobs – whether that means accessing hospital systems, contributing to safeguarding decisions, or maintaining continuity of care – is frequently shaped by factors outside their control. Put simply, hospital-based youth work is not yet consistently embedded or understood as a core part of the health, care and violence reduction landscape.

What this paper aims to do

Since October 2023, Social Finance has been working as a learning partner to the London Violence Reduction Unit (VRU) and the three main delivery organisations – St Giles Trust, Oasis Youth Service, and Catch22's Redthread services – with support from systems change advisor and founder of the Awareness TAP, Lennina Ofori. Our role has been to explore what helps and hinders hospital-based youth work, both in day-to-day delivery and in the broader systems it sits within.

Over the course of the partnership, we have:

- Run workshops with frontline practitioners and service managers to explore challenges and opportunities
- Supported youth work providers to improve how they collect and use data
- Led quarterly performance reviews, using data analysis to inform learning and planning
- Helped embed a culture of continuous reflection and improvement
- Engaged with partners across health, local government, policing and more to understand how HBYW is experienced and perceived within the wider system

Through this work, we've surfaced not only the practical barriers that practitioners face but also the deeper systemic dynamics that drive them: how power, policy, funding, perception and relationships shape the effectiveness of the service.

This paper brings those insights together to provide the basis for long-term system change. It moves beyond surface-level fixes to examine the underlying factors that hold the current system in place. We identify five root issues that cut across services and settings; they are entrenched patterns that both constrain the model and point to where real change can happen. Finally, we offer a set of targeted, practical recommendations for VRUs (particularly the London VRU) as lead co-ordinators in embedding public health approaches to violence in their regions, local authorities, NHS trusts and ICBs, youth work providers and national government. While these recommendations are grounded in our work with the London VRU and are designed to support immediate improvements and longer-term system transformation in London, many of them will still be highly relevant and applicable for VRUs and partners working outside of London.

This paper should be seen as complementary to existing guidance, including the *Youth Endowment Fund's A&E Navigator Programmes* report[1] and the Violence Reduction Programme London's *In-Hospital Violence Reduction Services: A Guide to Effective Implementation*[2]. While those documents provide detailed guidance on service delivery and address many of the operational challenges also surfaced here, this paper takes a systems-change perspective. It focuses on the wider shifts needed across policy, commissioning, and cross-sector collaboration to embed hospital-based youth work more fully into local and national systems. Our intention is that this paper contributes to making hospital-based youth work a vital and fully recognised part of the system of support for young people affected by violence to lead flourishing lives.

[1] Youth Endowment Fund, (2021). A & E Navigators Programmes Implementation Resource.
[2] Violence Reduction Programme London's (2022). In-Hospital Violence Reduction Services: A Guide to Effective Implementation

The History and Strategic Role of Violence Reduction Units

This paper has been commissioned by the London Violence Reduction Unit to explore how hospital-based youth work can be better embedded into systems across health, policing, and local government.

The first Violence Reduction Unit was established in Glasgow by Strathclyde Police in 2005 in response to rising rates of homicide and gang violence. It pioneered a public health approach to violence, treating it as a preventable outcome of multiple social and structural factors. In 2006, the Unit expanded to become the national Scottish Violence Reduction Unit, covering the whole of Scotland and broadening the reach and influence of this approach.

In 2019, the London VRU was launched by Mayor Sadiq Khan, followed shortly by a national announcement from then Home Secretary Sajid Javid, who confirmed funding for VRUs in 18 areas across England and Wales. London's VRU remains distinct in its structure: unlike most VRUs, which sit under Police and Crime Commissioners (PCCs), the London VRU is based within the Mayor's Office for Policing and Crime (MOPAC). This gives it a unique position within a highly complex city landscape, where local authorities (LAs) are responsible for individual boroughs and five Integrated Care Boards (ICBs) oversee broader health priorities.

VRUs are intended to lead partnership-driven, relationship-based approaches to violence reduction. Grounded in the public health model, they bring together key stakeholders – including the police, NHS, local authorities, and the voluntary and community sector – to address violence as a systemic and preventable issue.

Hospital-based youth work is a clear example of this approach in action. The intervention aims to support young people affected by violence or exploitation, typically following presentation at an A&E or MTC, by providing timely, trauma-informed support through trusted, relatable adults. Though referred to by different names across the country, including "A&E Navigators", the core model and principles remain consistent, and are commissioned by VRUs nationwide. According to the YEF Toolkit[3], the estimated impact of the service is deemed to be "high" i.e. in the top third of violence interventions, but the evidence base itself is relatively small, with only two evaluations that have looked explicitly at violent re-offending. However, as aligned with the public health approach, the aim of this service is to contribute to more than just a reduction in re-offending – it should contribute to, for example, a reduction in hospital admissions and engagement with education, employment or training. The VRU has commissioned the Behavioural Insights Team to complete a robust evaluation of the service in their commissioned sites in London, which we expect to be released in 2026.

The analysis and recommendations in this paper are rooted in learning from London and the role played by the London VRU. However, they are equally relevant to other VRUs commissioning hospital-based youth work or A&E Navigators, as well as to national government and system partners working to prevent violence through joined-up, public health-informed strategies.

[3] Youth Endowment Fund, YEF Toolkit. Available at: https://youthendowmentfund.org.uk/toolkit/ (Accessed: 23 June 2025).

The ‘System’ around Hospital Based Youth Work and Why It Matters

Throughout our learning partnership, we have applied a systems lens to explore the enablers and barriers of the HBYW service and understand the interconnected root causes that drive them. Our aim in this section is to explain what we mean by a “system” and “systems change,” which will underpin the recommendations in this paper.

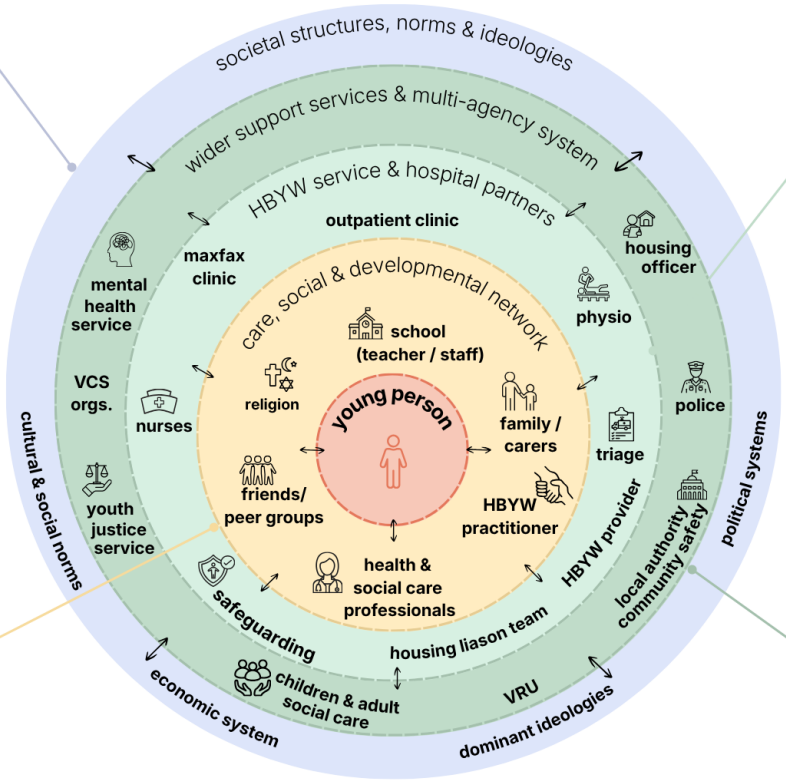
A system has boundaries – but these aren’t fixed. They are determined by the problem, its context and how each is framed. In this report, we describe the HBYW system from the perspective of the young people that the service is designed to support. While the hospital could be seen as a system itself, the service relies on a wider ecosystem including young people’s peers, families, schools, social care, police and other partners.

The HBYW system includes both **formal** and **informal** components. **Formal** structures include protocols, policies and the role of specific organisations – such as commissioners, hospital trusts, recruitment policies, voluntary & community sector (VCS) organisations. **Informal** components such as cultural perceptions, unwritten rules and relational dynamics influence how the formal structures operate in practice and shape the quality of interactions between them. While Figure 1 below illustrates the systems’ key components, it does not fully reflect the complex and evolving relationships between them. The boundaries between “levels” of the system represented by each circle are not fixed – decisions and interactions in one part are often shaped by pressures and behaviours from another. Viewing the service through a systems lens shows that embedding the service effectively requires change across the wider system, beyond the service itself.

The “System” Surrounding Young People in the HBYW Service

There are wider societal structures, norms and perceptions that influence how youth work is valued and integrated such as:

- Attitudes and perceptions of YP affected violence (intersections with race, ethnicity, class, gender)
- Understanding YP needs and impact of violence or exploitation related injury
- Perception of youth workers
- Perception of the HBYW service
- Approaches to contextual safeguarding
- National funding and policy priorities



Alongside the hospital and HBYW staff that the young person interacts with, there are formal and informal structures, processes, and infrastructure shaping how the service operate such as:

- Hospital honorary contracts and access to hospital data systems
- Physical space within the hospital
- Hospital staff constraints & recruitment cycles
- Buy-in from strategic & operational hospital staff
- Interactions between HBYW practitioners and hospital staff
- Provider’s recruitment, onboarding and training practices
- HBYW site team’s capacity

The young person’s immediate care, social and developmental network includes the people who directly interact with the YP, and structures that influence their day-to-day experiences.

The interactions and connections between these actors and structures (e.g., the interaction between their parent & teacher, or the HBYW practitioner & their social worker) also shape their experiences.

Outside of the hospital, there are other cross-sector actors and structures that are directly involved or indirectly shapes the support the young person receives:

- Support from leadership (e.g., Head of Community Safety)
- Serious Violence Duty response
- Interaction with HBYW practitioners
- Service funding cycles
- Commissioning approach

***Figure 1**: The HBYW System[4] – Mapping the organisations, individuals and relationships around a young person in the HBYW service, and the informal structures that influence them. The partners that young people engage within and outside of the service will vary across sites and depends on their support needs. This mapping reflects the breadth of partners that interact with young people across the HBYW Programme.*

Changing the behaviour or decisions of individual actors or organisations isn't about engaging them in isolation. In our blog titled "**Leading systems change: Three key lessons"**[5] we wrote:

> "
>
> Systems change is a term used to describe the process of tackling entrenched problems to achieve sustainable results. It can involve reforming policies, funding, strategy, culture, mindsets, relationships and more to create the deep shifts sometimes needed to generate better outcomes.
>
> "

Embedding hospital-based youth work more fully into the fabric of local systems means shifting the underlying conditions that shape how people behave and make decisions, how practitioners are perceived, how individuals and organisations interact, and how relationships are built and sustained. Progress depends on pulling multiple levers at once, in ways that recognise how these elements interact and influence one another.

Addressing violence that impacts young people is a system-wide challenge. While hospital-based youth work reaches young people at critical moments, its long-term impact depends on coordinated efforts across health, education, social care, policing, and other sectors. This is not only about responding to young people in crisis but also about preventing harm and building more responsive, equitable systems around them. This paper is designed to speak to the entire system around young people affected by violence, within the context of hospital-based youth work, to push forward system change.

[4] This system map was developed based on Bronfenbrenner's Ecological Systems Theory (1997). Simply Psychology. (2025). Access here: https://www.simplypsychology.org/bronfenbrenner.html
[5] Social Finance, (2023). Leading System Change: Three Key Lessons.

Insights on Enablers and Barriers for Hospital-based Youth Work

Over the course of the learning partnership, we've gathered a huge amount of insights on what it looks like to deliver hospital-based youth work. These insights span both the practical realities of delivering the service day-to-day, and the broader system conditions that shape how embedded and impactful the work can be.

In this section we attempt to group these insights into four themes that are contextualised to Hospital-Based Youth Work:

1. **Practice and Delivery –** The quality, consistency and adaptability of frontline delivery – including how practitioners engage young people, work with clinical teams, and operate across hospital sites.
2. **Hospital Infrastructure and Processes –** The day-to-day hospital systems and policies that enable or constrain practitioners – from onboarding and access to data, to space, multi-agency meetings, and referral pathways.
3. **Culture and Legitimacy –** The perceptions, values and power dynamics that shape how HBYW is understood, respected and integrated within hospital environments and joint decision-making.
4. **Strategic Ownership and Alignment** – The broader commissioning, policy and system-level factors – including who funds and champions the work, how it aligns with health priorities, and the implementation of public health principles.

The purpose of this is to group the learnings and insights in digestible and accessible ways, and to then utilise these groupings to identify the underlying system challenges.

1. Practice and Delivery

This section focuses on the conditions for success in relation to the practice models and how they are delivered within the hospital environment. It also includes points regarding organisational ways of working for youth work providers, and how commissioning models impact learning.

Finding and nurturing talent is key

The hospital-based youth work role is a highly challenging profession. There is variation across the youth work providers regarding what the role is called e.g., practitioner or youth worker, but regardless, the challenge of the role is not reflected in the name of the service or the role. Developing the broad set of skills to deliver the role effectively requires clear communication to prospective candidates, solid recruitment processes to find the right people, and comprehensive support in delivering the work. Staff are called on to work with young people during often their most traumatic moments where there is extreme emotion – fear, anger, grief – which requires a huge amount of emotional resilience. Working through these emotions with them can be highly challenging.

The role also requires a huge amount of cultural understanding and nuance to be able to understand young people and their positions, and resonate with them, and be seen as someone who can be trusted and is not "another professional". Part of this is also demonstrating confidence, particularly in feeling able to be respected or even looked up to by young people.

Engagement takes creativity and care

In terms of face-to-face engagement, practitioners have different techniques – they might offer to do something useful like fixing a phone that's smashed or getting a young person food. Young people will often be cautious about engaging with the service based on past experiences with professionals – they may see them as untrustworthy or be fearful of incriminating themselves or others – and practitioners are required to navigate that distrust.

Often, either due to a young person being admitted and discharged prior to a practitioner meeting them, practitioners will have to try to engage a young person in the service over the phone. This requires a strong skillset in terms of being able to keep a young person interested and being able to engage with them in familiar terms. This is also balanced with the need to potentially engage their parents and carers who may have their own anxieties around the service, or speaking to them may open up a whole different level of risk such as the family itself being in danger.

Practitioners have to navigate complex systems

At the same time, there is a "systems navigation" skillset required. Hospital-based youth work practitioners must be able to navigate the hospital, social care, housing and community. Examples of this might mean being able to advocate to have a young person not be discharged due to being at risk in the community and concurrently trying to get housing sorted for the young person and their family. This requires not only an understanding of the system but robust training, particularly for staff who would be coming from a more traditional youth-work environment in the community.

Cases are highly complex

Cases are often highly complex, and that's reflected in the kinds of training that staff say they want – but due to a lack of capacity they've often not had the opportunity to access it. Practitioners talk about wanting more training on things like SEND – many young people come into hospital with SEND needs that may or may not have been diagnosed. They've also highlighted the need for training on child sexual exploitation (CSE), especially in relation to young girls, and child criminal exploitation (CCE). Mental health also comes up regularly – the reality is that many cases sit across multiple issues, and practitioners are being asked to support young people with hugely complex and overlapping needs.

Being a "Trusted Adult" comes with emotional strain

From a wellbeing and support element, there is also the strain on staff from a relational perspective. On many occasions, they will become a key "trusted adult" in the young person's life, which itself will often be chaotic. This role can be highly emotionally draining, particularly given that many of the practitioners will stay in contact with young people after their cases close to ensure that a) they can be followed up with to evidence impact and b) to ensure the young person feels able to re-engage if they need to. Often young people may not feel they need to but will let their practitioner know how they're doing regardless.

Peer-led training helps embed best practice

While there is no "perfect" way of being a practitioner and there are multiple equally valid approaches and personalities, we see differences across youth work providers in terms of willingness to practice peer-led training **internally**. There will be substantial differences across hospital sites even when led by the same youth work provider, and there may not be frequent opportunities for good practice to be identified and shared across them. Part of this will be down to structural challenges in having staff work across hospitals. Nonetheless, we saw good practice in relation to identifying someone who is good at a particular task – e.g. phone calls to young people –

and disseminating this practice across a site, setting a standard for others to follow. Again, while people will have different approaches and styles, this focus on identifying what works brings an additional level of support to practitioners who may need guidance on what to do and what not to do.

Case Study: St. Giles Trust's approach to onboarding hospital-based youth work practitioners workers recognises the role's complexity and the support practitioners need before they take on their first cases. Operating a lived experience model, they've developed processes that recognise both the strengths practitioners bring and the additional support they may need.

New practitioners complete a recruitment risk assessment covering areas like mental health, substance use, and offending history. The service manager reviews this with the newly recruited practitioner to develop a tailored support plan, which is then signed off by the head of services. This process ensures accountability across the organisation for managing the risks for practitioners and the young people they support that are inherent in working in this traumatic environment and sector.

The induction process also matches this intentionality. New practitioners complete 3-4 weeks of preparation before taking on cases, including mandatory training, frequent line management meetings, shadowing other practitioners and sites, and a buddy system pairing them with senior practitioners. Shadowing real-time engagement, such as supporting young people at the point of hospital presentation or "cold-calling" to offer the service by phone, helps new practitioners understand what day-to-day work entails and what good practice looks like. This hands-on training and ongoing support helps practitioners build confidence and competence gradually, offering practical examples to drawn on and develop essential skills to work on the frontline.

A culture of shared learnings requires the right commissioning structure

Part of our role as learning partner was to support youth work providers to share learnings with each other – and we found that front-line practitioners gave highly positive feedback and appreciated the opportunity to learn from other practitioners from other organisations with completely different ways of tackling problems. To do this more effectively though, and to encourage more collaboration on practice requires commissioning approaches that do not penalise the sharing of learnings due to competitive approaches – as it requires organisations at the management levels to be willing to not only take on learning from other youth work providers, but to feel comfortable sharing their own learnings.

Summary

The insights in this section demonstrate a few things, two being: a) the need to hire the right staff and being clear on what skills are required and b) the need to invest in training, the sharing of practice, wellbeing support and pathways for progress to build and retain talented staff. However, it also reflects on the challenging environment that practitioners walk into – and how that is a symptom of the underappreciation of the service. We discuss this in more detail later in relation to culture and legitimacy (see pg. 15, 16). It's important to highlight that retention is also often due to factors outside of the youth work provider's control (see pg. 17). The insights also touch lightly on commissioning models , we discuss this further later on in the paper (pg. 20)

2. Hospital Infrastructure and Processes

This section focuses on the hospital environment and how well hospital-based youth work is integrated within hospital systems and processes. Many of the points below relate to what makes practitioners feel like they are genuinely "part of the team" – from their own perspectives, but also from the viewpoint of clinicians and other professionals they work alongside.

Integration and visibility go hand in hand

Early on in the learning partnership, we heard that in some hospitals staff didn't have a physical designated space to work from between cases – which meant basing themselves in the community instead. Unsurprisingly, this led to missed referrals. While the work involves a lot of face-to-face contact with young people, it also includes time spent on the phone with families and professionals, or doing paperwork – none of which is easy to manage without a consistent physical base inside the hospital.

Being on-site is critical to proactively identify young people, or to receive verbal referrals directly from clinical staff. The issue here isn't just about presence – it's about visibility and integration. Not being physically there can contribute to (and result from) a wider lack of embeddedness. If practitioners aren't visible, they're more likely to be seen as external to the hospital, and less likely to be referred to.

Given the turnover of clinical staff, it's important to have that regular visibility and opportunity to build relationships. Training delivered by the youth work providers is frequent – which is required to ensure that new staff are onboarded. Some sites have identified clinical champions who are effective at getting new staff knowledgeable about the service concurrently.

When services are perceived as "other," referrals tend to become overly formalised – reliant on online pathways or emails. These often result in lower volumes of referrals, and delays in getting to young people during a reachable moment.

On the other hand, where things are working well, we've seen good practice around giving practitioners a clear, designated space to work from. Ideally this space would be close to the wards so they can engage quickly with young people Some provider teams are co-located with other professionals (e.g., hospital safeguarding teams). This proximity helps with logistics and supports

relationship-building. Being in the same space allows for informal conversations and peer learning, which in turn builds trust and credibility in the youth work offer across the wider hospital team, making it easier for practitioners to liaise with, for example, discharge teams, safeguarding etc.

We heard anecdotal evidence that an unexpected positive of having HBYW practitioners in the hospital setting related to youth workers often being the only adults able to engage with young people in crisis without escalating the situation. Practitioners often help de-escalate and advocate for young people and adults who are scared or angry, reflecting the trauma-informed skill set that underpins their practice.

Case Study: At North Middlesex University Hospital, the Oasis Youth Services team demonstrates how having dedicated office space and co-locating with key hospital partners shapes HBYW service delivery. Being located in the same building as adult and children's safeguarding teams, Paediatric Liaison Health Visitors (PLHV), CAMHS services, and social workers creates opportunities for informal knowledge sharing and real-time, integrated support so fewer young people fall through the gaps between services.

When safeguarding staff identify young people who may present as "low concern" and aren't referred to the service from A&E, both teams have in-person discussions about the young person's support needs, with HBYW practitioners sharing insights on the local context and risks of extrafamilial harm. This often leads to practitioners attending discharge planning meetings, offering the service to families or carers, or contacting young people directly - reducing delays or missed referrals that might otherwise prevent young people from accessing support.

Co-location with hospital-based CAMHS has enabled practitioners to build trusted relationships with professionals, contributing to more seamless referrals when mental health assessments surface violence-related risks. The PHLV team also regularly refers eligible young people and connects practitioners with services like school nurse to ensure joined-up community support.

By being visible and working in close proximity with hospital staff, the OYS team describes being "seen as colleagues, not an external service who come and go." This perception shift reinforces practitioners' role and expertise, and enables more coordinated care for young people affected by violence.

Honorary contract delays are a significant blocker

The challenges with regards to embeddedness can arise from when a new staff member is hired, namely in relation to honorary contracts.

Staff need honorary contracts to independently work with patients in the hospital and to access hospital systems. A consistent challenge we've heard is that this can take months to complete – that means months of the new staff member essentially not being able to do their job. Even where it's useful for a bit of downtime before starting, for training for example, this stretches on much longer than is required or is practical, as there is very little that workers can do without having this contract in place. This leads to huge inefficiencies salary-wise and means many young people will be missed.

Getting these honorary contracts in place relies heavily on a) the internal processes within the hospital in doing so, and whether there is a clear, agile process and b) the ability for youth work providers to be able to navigate that system, being able to get in touch with the right people at the right time to push it along. Having an internal champion who's willing to push internally to do so is massively helpful though not every site will have that person. They would usually need to be quite senior as opposed to a front-line clinician.

Another challenge with honorary contracts is that they are trust specific. This is a real challenge in getting practitioners to be able to spend time at different hospitals, promoting cross-fertilisation of learnings. This doesn't relate only to the practice of youth work providers – trusts also often need to be convinced to change their internal practices by having evidence from other hospitals. Without that direct experience for the practitioners to say, "at this hospital, they do this," many suggestions that would be highly effective are not adopted. It also limits flexibility, making it harder for youth work providers to reallocate resource across sites when there are spikes or staff turnover.

Data access is variable, and influences referral pathways

Honorary contracts are also important because practitioners are unable to access data systems without them. However, even with honorary contracts there is a huge variance in terms of what data practitioners can access and this impacts referral numbers. Some practitioners have full access to internal data systems, enabling them to see young people in real time and retrospectively. This supports timely engagement with young people and facilitates easier identification of eligible young people, reducing the friction for clinical staff. However, others have limited access – e.g. only real-time A&E alerts, which means they miss out-of-hours presentations and rely on email referrals from busy clinical teams. Referral routes vary widely, from digital systems to informal conversations or emails. When hospital staff are unaware or overloaded, referrals often don't occur, resulting in missed opportunities.

Case Study: Catch22's Redthread team at Homerton University Hospital was missing some eligible young people because of restrictive data access rules. Practitioners couldn't contact young people over-18 post-discharge without clinicians obtaining consent during their hospital visit. These barriers created bottlenecks and added pressure for clinical staff to manage alongside their clinical responsibilities.

Recognising how these restrictions were limiting referrals, the team worked with strategic and operational hospital staff to review and update their Standard Operating Procedures (SOPs). The revised SOPs now allow practitioners to screen hospital systems for eligible young people over 18 and make direct contact, following a risk assessment to ensure it is safe to engage.

Developing the updated SOPs required significant collaboration from clinical leads, department heads and safeguarding teams. Early signs suggest these changes are contributing to more young people over 18 being offered the service, including young people without an existing support network, and reducing the referral burden on clinical teams.

Data access (and quality) is also crucial to support long-term evaluations

Beyond its impact on referrals, access to NHS data is also critical for long-term, robust evaluation of HBYW. As part of this learning partnership, we conducted an assessment of the data collected by youth work providers to support the Behavioural Insights Team's evaluation. We also reviewed the quality and consistency of this data.

While further discussion on how HBYW can be evaluated is needed outside of this paper, building on the Behavioural Insight's Team's learning from the process of doing so, one key point raised from this work is that understanding the long-term impact of HBYW requires access to Emergency Care Data Set (ECDS) datasets which covers key health data. To link data held by youth work providers to this data evaluators need NHS numbers for the young people who are supported by the service. This usually requires hospital trusts and youth work providers to have the appropriate data-sharing agreements in place. Without this infrastructure, some of the more quantitative impact may be unrecognised.

Summary

This section explores how hospital infrastructure and processes shape the visibility and integration of hospital-based youth work practitioners. It shows that when practitioners lack physical presence or a designated space in the hospital, referrals drop and opportunities for informal collaboration disappear. Delays in honorary contracts and data access further hinder practitioners' ability to work effectively (as well as proving the long-term impact of the service via robust evaluations), while variation in safeguarding engagement can leave some young people unsupported. These factors combine to affect how well HBYW can work alongside hospitals as part of the broader team, rather than feeling external or peripheral.

3. Culture and Legitimacy

In this section, we explore the challenges facing the service through the lens of how hospital-based youth work – its practitioners and the young people it supports – are seen and understood within the hospital and broader systems. The central focus here is on the legitimacy of the service, as reflected in the everyday experiences practitioners have on the ground.

Perceptions of the Service, Practitioners, and Young People must be challenged

The National Youth Agency's 2024 *Youth Sector Workforce Survey*[6] highlights sector-wide concerns about status and recognition.

[6] National Youth Agency, (2024). Youth Sector Workforce Survey Report 2024.

> [Youth workers] are less confident…that other youth professionals understand the role, or indeed the value of youth work. Some would welcome the strengthening of the youth work identity to challenge the perception that 'anyone can do youth work'"

As youth work increasingly becomes the remit of primarily VCS organisations, these dynamics are even more acute. This can be seen at times in hospital-based youth work. Practitioners in this space sometimes feel disrespected and dismissed – not just by some hospital staff, but also by others across the system, such as housing officers, social workers, and safeguarding teams. Some referred to themselves as "second class citizens" in the wider network of support around a young person.

Part of the power of the service lies in its distinctiveness – for example, dressing in a more relaxed and approachable way, or using language that resonates with young people. But this difference, while intentional and relationally effective, is sometimes unfairly interpreted as unprofessional. Combined with the fact that practitioners are independently commissioned (and not embedded within the hospital or local authority structure), this can mean they're seen as "add-ons" rather than a core part of the system.

All of this feeds into an implicit professional hierarchy, where practitioners are viewed as less important than clinical staff and social workers – regardless of the strength of their relationship with a young person, or the insight they bring. This can affect whether they are included in key decision-making processes. There is variation across sites in how involved practitioners are in multi-agency meetings – both inside the hospital and in the wider locality. When they're not at the table, they can't contribute critical insight or challenge decision-making that doesn't account for the broader picture of a young person's life.

With the police, this dynamic can be particularly damaging. We heard examples where police officers refused to allow practitioners to speak to a young person in hospital or insisted on being present during conversations. These decisions can destroy the trust practitioners are trying to build – often with those most reluctant to engage with services.

Importantly, these challenges don't just affect how practitioners are seen – they also reflect how young people themselves are perceived. We heard multiple accounts of young people being viewed through a lens of risk or aggression – seen as "gang-involved" rather than traumatised, scared, or vulnerable. This can lead to less compassionate care and, in some cases, adultification – an often racialised issue treating young people as if they were much older than they are and holding them to adult standards of behaviour.

However, these challenges are absolutely not uniform across all sites. Many sites demonstrate real respect and appreciation of the service and its practitioners. Some practitioners reflected on how their presence within hospitals had helped to "humanise" young people in the eyes of other

professionals. We also heard positive stories of clinicians and police who were engaging completely differently with young people as a result of working alongside practitioners.

Youth work is rooted in contextual safeguarding

Hospital-based youth work is rooted in a trauma-informed, contextual safeguarding approach – one that seeks to understand a young person's wider world: where they live, how they get to school, what kind of harm might exist outside the family. This way of working is embedded in the wider youth work tradition, which typically allows for more flexibility and relational practice compared to more structured statutory roles, such as social work.

While contextual safeguarding is gaining traction within statutory services, many professionals are still early in their adoption of this approach. Often, they are constrained by institutional norms and risk-management frameworks that can make it harder to apply contextual safeguarding in full. This can create a tension between the more developed, practice-led approach of hospital-based youth work providers and the more cautious, hybrid models found within statutory systems.

You can at times see this tension in the language used to describe young people, and in the solutions proposed. When safeguarding is treated as a matter of individual behaviour rather than shaped by environment and context, it can undermine the core ethos of HBYW. More than that – it can have real consequences. Young people may avoid seeking care for fear of being criminalised, or incidents may be treated as isolated rather than part of a wider pattern of violence in an area.

Generally, we see more positive experiences in relation to child safeguarding than adult safeguarding, but this can cause challenges in supporting young people as they transition into adult services as adult safeguarding tend to have more expertise in supporting older adults than to young adults.

Housing constraints significantly impact young people

Nowhere is this tension more evident than in housing and discharge. Youth workers often find themselves advocating for a young person to be re-housed – because returning to their previous address might place them at ongoing risk. Doing so is incredibly challenging as risk of violence may not always be seen as a priority within the LA housing team, who themselves face extremely pressured conditions. At the same time, clinical teams are under intense pressure to discharge quickly. This creates a tug-of-war and places the practitioner in an impossible position: trying to uphold the principles of contextual safeguarding in a system that often cannot accommodate them.

Summary

This section highlights how perceptions of hospital-based youth work and the young people it supports directly affect how the service is valued and included in decision-making. Practitioners often feel marginalised, seen as less professional, and excluded from safeguarding discussions, particularly when their contextual, trauma-informed approach to working with young people doesn't align with more individualised or risk-averse ways of working. These tensions can have real impacts – from disrupting trust to creating barriers to safe housing and discharge. Despite these challenges, positive examples show how youth work can help shift perceptions and humanise young people in the eyes of professionals.

4. Strategic Ownership and Alignment

This section explores how strategic ownership and alignment affect the stability and sustainability of hospital-based youth work. It examines the impacts of short-term funding, the limits of current commissioning structures, and the need to integrate the service more fully into the NHS's prevention and community-based agenda.

Funding uncertainty impacts workforce

As with many commissioned services, hospital-based youth work faces ongoing uncertainty around funding. The London VRU receives its funding directly from the Home Office, which it then allocates to commissioned HBYW services. A recent one-year funding extension for VRUs was confirmed late, leaving youth work providers in a difficult position – caught between preparing for potential service wind-down and trying to sustain momentum.

Stakeholders must take ownership of the service

Much of the challenge surrounding HBYW lies in the broader issue of strategic ownership. VRUs were established to champion public health approaches to serious violence, and their leadership has been instrumental in enabling services like HBYW to exist. In many ways, VRUs have filled a strategic vacuum – investing in a model that doesn't fit neatly within traditional commissioning structures. Unlike some other issues affecting young people violence doesn't and shouldn't sit neatly within a single institutional remit.

This kind of multi-agency, cross-sector ownership is essential to effectively addressing serious violence. However, it also introduces risks. When VRUs become the primary source of funding and strategic direction, it can inadvertently dilute the sense of responsibility among other key stakeholders, such as ICBs, NHS trusts, and local authorities. Over-reliance on VRUs risks reinforcing the perception that HBYW is "someone else's responsibility."

London's VRU, for example, has provided vital strategic leadership and, as a regional body, offers valuable oversight and connectivity across the city. It plays a crucial role in both commissioning and championing HBYW. Yet, its leadership alone is not sufficient. Without shared ownership and investment from other stakeholders, the sustainability and integration of hospital-based youth work remain at risk.

HBYW can feel alienated due to its positionality

This raises a structural tension at the heart of the service. Hospital-based youth work operates *within* the NHS – physically and operationally – but its funding and oversight come from *outside* it. That disconnect limits the service's ability to embed fully into hospital systems, and to align with health priorities in a strategic and sustainable way.

We've already discussed the practical consequences of this in earlier (pg. 15, 16) – for example, how it shapes practitioner access to hospital systems, or reinforces their outsider status. But it also speaks to something more fundamental: if hospital-based youth work is to thrive in the long term, it must be better integrated into NHS strategies and planning processes.

The service must align with NHS Priorities

That integration feels particularly urgent in light of the NHS's direction of travel. With the release of the NHS 10 Year Health Plan emphasising the shift from hospital-based care to prevention and

community support, there is a clear strategic fit for hospital-based youth work. The service already plays a crucial role in de-escalating crises, preventing repeat admissions, and supporting safer discharge – all of which align with this shift.

Recent NHS guidance around "Neighbourhood Health"[7] has also highlighted the importance of community-based models of health and care. However, as the King's Fund[8] has pointed out, there is a risk that these conversations become too narrowly focused on health actors – overlooking the critical role of local government, voluntary organisations, and community-based practitioners.

VRUs, alongside youth work providers, have a critical role to play in both coordinating delivery in hospitals across regions and advocating for this integration. It's essential that they position hospital-based youth work as a key component of the shift to neighbourhood care and prevention – not as an add-on, but as an embedded part of the system.

Summary

In this section, we've shown how strategic ownership and alignment shape what's possible for hospital-based youth work. Uncertainty in funding has real impacts on staff stability. While VRUs have been crucial in championing the work, their leadership alone can't solve the deeper tension: hospital-based youth work lives within NHS settings, but its funding and strategic home sits elsewhere. As the NHS increasingly moves towards shifting care from hospitals to communities, there's a real opportunity to position hospital-based youth work as a core part of that future given it does exactly that. But this will only happen if it's properly embedded into NHS and local system priorities, and if VRUs, ICBs, NHS trusts, local authorities and youth work providers all take shared responsibility for making it work.

[7] NHS England, (2025). Neighbourhood Health Guidelines 2025/26.
[8] King's Fund, (2025). Neighbourhood health: the idea isn't radical but implementing it would be.

Root Issues and Strategic Leverage Points

The insights in the previous section are broad, and the focus of this paper is to identify where to effectively concentrate efforts for system change. To do that, we look beneath the surface of individual challenges to identify the underlying root factors that drive them. While these are often deeply entrenched, they also represent clear opportunities for intervention. By tackling these systemic issues directly, there is real potential to improve the context in which hospital-based youth work operates and the outcomes it achieves for young people.

Below we outline five core and overlapping root issues.

1. HBYW is seen as peripheral by key stakeholders, despite its alignment with their priorities and its grounding in the public health approach

Although hospital-based youth work is grounded in the public health approach and is recognised as a government manifesto commitment – with Violence Reduction Units securing funding to deliver the programme in 2025/26 – it continues to be perceived by many key stakeholders, including the NHS, as a peripheral initiative. Rather than being seen as a core component of national and local strategies for health, young people, and violence reduction, it remains on the margins. This perception – not helped by short-term, limited investment – is rooted in a lack of clarity about where the service fits within existing systems and means that the service often sits outside local health priorities. As a result, HBYW is disconnected from national key agendas such as the NHS 10 Year Health Plan, Neighbourhood and Community-Based Care, and efforts to reduce health inequalities, despite its very clear alignment with them. This disconnect not only weakens the service's integration into mainstream systems but also limits its ability to demonstrate its broader value to public health and care outcomes.

The service is also not yet meaningfully aligned in public narratives with cross-government initiatives such as the Young Futures Hubs and Prevention Partnerships, which aim to reduce the impact of violence on young people and address rising mental health needs – despite the clear parallels. Without clear integration into these agendas, hospital-based youth work risks relying on unstable, short-term cycles, and its full potential to support long-term outcomes for young people will remain unrealised. Realising this potential requires reframing the service not just as a violence reduction tool, but as a vital, cross-cutting intervention that supports young people's wellbeing across health, social care, and education.

2. The commissioning model limits cross-sector partnerships and sustainability

The London VRU's commissioning **approach** is long-term by design, shown through its work with Social Finance as a learning partner and the Behavioural Insights Team as evaluator. There's a focus on driving performance through peer learning and encouraging youth work providers to share practice, fitting with the VRU's role as a strategic commissioner.

But the current commissioning **model** doesn't fully reflect these principles. In London, where multiple youth work providers are contracted, too much focus on competition may discourages collaboration and limit youth work providers' ability to influence long-term strategy. The model also lacks accountability mechanisms for hospitals hosting the service or local authority teams supporting young people on discharge. It doesn't have formal mechanisms to encourage hospitals and LA teams to take on an active role in mobilisation or to tackle barriers like integration of practitioners, delayed communication, limited involvement in multi-agency meetings, or access to honorary contracts that occur during delivery of the service. Additionally, short-term contracts and funding cycles caused by a lack of long-term settlement also make it hard for youth work providers to build lasting relationships with local stakeholders and to retain staff.

3. Trusts do not consistently and formally integrate the service into the hospital

Some NHS trusts have not consistently adapted their infrastructure to support the delivery of hospital-based youth work. Without formal structures in place, the service can struggle to gain the visibility, access, and support required to operate effectively within hospitals.

Core operational enablers remain relatively inconsistent across sites. In some hospitals, youth work providers are co-located with key internal teams and have access to NHS data systems, while in others, this is missing. Processes such as issuing honorary contracts for practitioners (likely the most obstructive factor in working with young people), getting referrals, or receiving information are often informal, improvised, or reliant on individual goodwill.

This informal set-up reinforces an unbalanced expectation that practitioners and youth work providers must "navigate the system" on a case-by-case basis, leaning on personal relationships, soft influence, or workarounds to deliver the service. While many succeed in doing so, this is fragile, inconsistent, and unsustainable in the long term. It also distracts practitioners from their work with young people and perpetuates the view of the service as peripheral rather than embedded.

Ultimately, at some hospitals, HBYW remains outside the core business of the hospital. As a result, it is vulnerable to changes in leadership, staff turnover, and competing pressures. Without formal routes to embed the service, HBYW will continue to be embedded at variable degrees.

4. Professionals have differing approaches to supporting young people affected by violence

HBYW practitioners are specialists in contextual safeguarding – a core element of youth work practice that recognises the complex social environments in which young people live. While many professionals in hospitals and local authorities are beginning to adopt these principles, they often operate within more rigid, risk-averse frameworks that prioritise immediate risk management and procedural compliance. This creates a disconnect.

HBYW practitioners, who take a more flexible, relational approach, are often further along in applying contextual safeguarding in practice. They focus not only on immediate safety but also on the broader social dynamics that shape a young person's vulnerability – such as threats in their community, peer networks, or housing instability. These wider risks are not always fully acknowledged in statutory decision-making, particularly in areas like housing, where systemic constraints can override nuanced understanding. In these contexts, young people – especially those from racialised backgrounds – can be subject to adultification, where vulnerability is downplayed, and they are treated as more responsible or resilient than they are. As a result, practitioners often find themselves advocating strongly to ensure these risks are recognised and addressed. This tension can contribute to inconsistent support and fragmented experiences for young people navigating complex systems.

5. Unspoken beliefs and hierarchies influence collaboration and decision-making

Professionals' assumptions about young people impacted by violence and about youth work can impact how they see and engage with the HBYW service. Likewise, young people affected by violence are frequently judged through a narrow lens focused on behaviour, rather than being seen as vulnerable individuals with complex, unmet needs. These assumptions influence practices around making referrals, information-sharing, and safeguarding young people.

These mental models can reflect an unspoken professional hierarchy across health, social care, police, and youth work. How practitioners are included in meetings, consulted on safeguarding decisions, or given access to spaces and systems indicates what kinds of expertise are valued. These power and relational dynamics don't just affect youth workers – they also shape how young people are seen and supported. This entrenched hierarchy creates an uneven playing field; practitioners often have to fight to be recognised as professionals before they can properly advocate for the young people they work with.

That said, there is promising evidence of these mental models being challenged and broken down in particular sites, with relationships between practitioners, clinicians, and other staff strengthening. Practitioners have noticed clinicians shifting how they see young people and showing genuine curiosity about how to support them better. Changing these deep-rooted beliefs is one of the toughest parts of system change.

Eleven Strategic Recommendations to Embed and Sustain Hospital-Based Youth Work

The **eleven recommendations** in this section are designed to tackle the root causes identified in the previous section. They reflect the strategic opportunity here to re-focus hospital-based youth work and embed it within systems as a sustainable and effective intervention. Each recommendation is designed to be practical and used as leverage to shift complex systems.

The recommendations are underpinned by the need to align HBYW with the priorities of its key system partners and articulate the value of the service to them. This includes national government, and particularly the Home Office as incumbent and long-term funders, but also the NHS. The service aligns closely with the NHS 10 Year Health Plan (which emphasises shifting care into communities), particularly as part of the neighbourhood health agenda. There's a clear opportunity to better articulate the service's impact on the health system more explicitly, including its role in reducing violence against hospital staff, supporting safer discharges, and relieving pressure on acute services. The VRU must also clearly demonstrate the service's relevance to the Serious Violence Duty (SVD) – a statutory driver of multi-agency collaboration to prevent and reduce serious violence.

They also reflect the crucial, on-going role that the London VRU must play in commissioning the HBYW service through a public health lens – bringing together police, health, local authorities, probation, and community partners. The London VRU is well-positioned to lead the broader shift, reframing HBYW as a preventative, neighbourhood-based public health intervention. This framing not only supports stronger system buy-in and long-term sustainability but also makes a compelling case for value and cost-effectiveness.

Finally, these recommendations are designed to build on the progress made by allied partners in the space. For example, the Violence Reduction Programme London has been a key partner in establishing violence as critical public health challenge and championing a public health-based approach to reducing violence. This is articulated in the In-Hospital Violence Reduction Services: A Guide to Effective Implementation[9]. These recommendations encourage partners to build on these tools, taking a similar approach to reframe HBYW in alignment with wider system priorities at a strategic level.

On the following page is a table demonstrating how the recommendations align with each of the root issues.

[9] Violence Reduction Programme London's (2022). In-Hospital Violence Reduction Services: A Guide to Effective Implementation

	Recommendations	Root Issue				
		HBYW is seen as peripheral by key stake-holders	Commissioning model limits cross-sector partnerships and sustainability	Trusts do not consistently and formally integrate the service into the hospital	Differing professional approaches to supporting YP affected by violence	Beliefs and unspoken hierarchies shape collaboration & decision-making
1	Build on the growing evidence base and policy alignment to secure long-term governmental funding	■	■			
2	Strengthen accountability by embedding hospitals and local authorities in commissioning structures from the outset	■	■	■	■	■
3	Support Local Authority engagement to improve joint working and continuity of care	■	■		■	■
4	Shift to a relational commissioning model that enables collaboration, shared accountability, and youth work provider influence over long-term strategy		■	■	■	
5	Integrate contextual safeguarding approaches and youth work expertise into multi-agency safeguarding forums				■	■
6	Use peer-to-peer learning to build core skills across the workforce, starting with system navigation				■	■
7	Develop system-level outcome measures to assess genuine adoption of the public health approach	■	■			
8	Codify and champion positive police-practitioner-young person relationships				■	■
9	Establish a cross-site learning forum for hospital leads and commissioners nationally			■		
10	Improve data collection, quality and infrastructure to demonstrate the full impact of the service	■	■	■		
11	Reframe and rebrand the HBYW practitioner role			■	■	■

Legend	
■	Recommendation addresses root factor explicitly

***Table 1**: Mapping each of the recommendations against the root issues, demonstrating how they are cross-cutting and designed to tackle multiple issues.*

Eleven strategic recommendations to embed and sustain hospital-based youth work

Recommendation 1: Build on the growing evidence base and policy alignment to secure long-term governmental funding

Relevant partner(s): National Government, VRUs

Hospital-based youth work requires stable, long-term funding cycles and contracts that reflect the realities of delivery, including the need to retain skilled staff, maintain visibility and awareness in the hospital and externally, and deliver consistent, safe support to young people. The short-term nature of the funding cycles, despite the service having been delivered since the mid-2000s, is one of the more fundamental challenges to embedding HBYW within systems.

The aims of the service – to support young people impacted by violence or exploitation and to disrupt cycles of harm – align directly with national priorities on community health, early intervention, and serious violence prevention. This is reflected in the Government's commitment to place youth workers in A&Es[10,11], the long-term aim of the *Safer Streets* mission to reduce serious harm[12], as well as the proposed Young Futures Hubs programme which brings together departments including the Department for Education, Department for Health and Social Care, Department for Culture, Media and Sport, the Ministry of Justice and (crucially) the Home Office, to establish a network of Young Futures Hubs and Young Futures Prevention Partnerships[13].

The Home Office and VRUs should use this growing alignment to make a compelling case for a long-term settlement. This case should also be backed by the growing body of evidence in support of the service. The forthcoming YEF A&E Navigators Review is expected to provide a mapping and review of A&E navigator services across the country, and the Behavioural Insight Team's full evaluation of the London VRU-commissioned services is expected to be published in mid-to-late 2026.

[10] House of Commons Written Question 22371 (Whittome to Home Office) Youth Work: Accident and Emergency Departments. Tabled 7 January 2025. Answered 15 January 2025.
[11] Labour Party, (2024). Change: Labour Party Manifesto.
[12] National Government, access here: https://www.gov.uk/missions/safer-streets
[13] House of Commons Written Question UIN 28305 (Mayer to House of Commons Commission) Children and Young People: Protection. Tabled 3 February 2025. Answered 14 February 2025.

Recommendation 2: Strengthen accountability by embedding hospitals and local authorities in commissioning structures from the outset

Relevant partner(s): VRUs, NHS Trusts / ICBs, Local Authorities

The commissioning model must do more to build shared accountability across all key partners. Hospitals should be involved early in the commissioning process, not just as delivery sites, regardless of whether they contribute financially or not. VRUs as lead commissioners should set out the conditions required for effective service delivery to enable trusts to assess whether their existing systems, infrastructure and culture can support it.

Local authority teams, particularly social care, housing, and Youth Justice Services, play an equally important role in supporting young people beyond the hospital. These teams should also be engaged from the outset of commissioning and delivery planning.

VRUs as lead commissioners should implement a clear, co-developed mobilisation process inclusive of a pre-launch mobilisation workshop with clinical and non-clinical staff within hospital settings. The purpose would be to identify potential or existing challenges – such as honorary contract processes, access to data systems, working space, staff induction, or attendance at safeguarding meetings – and co-develop a plan to address them. This process should build upon the In-Hospital Violence Reduction Services: A Guide to Effective Implementation[14]. A similar process should be undertaken with relevant local authority teams, particularly social care, housing, and YJS. The co-developed plans should be time-bound, reviewed regularly, and included in formal commissioning agreements or service-level expectations. This relates to new sites and recommissioned services.

Recommendation 3: Support Local Authority engagement to improve joint working and continuity of care

Relevant Partner(s): Local Authorities, Youth Work Providers, VRU

Local authorities play a critical role in enabling the wraparound support that hospital-based youth work relies on – from safeguarding and housing to education and youth services. There are also clear statutory duties, specifically the Serious Violence Duty[15], that requires them to engage with partners. Yet in practice, practitioners may face barriers such as exclusion from multi-agency and safeguarding meetings, delayed or withheld information and unclear guidance about statutory pathways.

LAs should take a clearer role in embedding the service within local safeguarding systems and ensuring structured collaboration with youth work providers. This includes timely and consistent information-sharing, clear guidelines on support and escalation pathways, and active inclusion of practitioners in exploitation panels and

[14] NHS Violence Reduction Programme London, In-Hospital Violence Reduction Services: A Guide to Effective Implementation, 2022.
[15] Home Office, (2023). Serious Violence Duty – Statutory Guidance. https://www.gov.uk/government/publications/serious-violence-duty

multi-agency forums. There is also an opportunity for LAs to co-commission the HBYW service, helping ensure alignment with local early help and prevention priorities and securing longer-term sustainability. The London VRU's ability to convene partners at a London-wide level should be used to support LAs to identify and embed best practice from other local areas.

Recommendation 4: Shift to a relational commissioning model that enables collaboration, shared accountability, and youth work provider influence over long-term strategy

Relevant partner(s): VRUs, Youth Work Providers, NHS Trusts / ICBs, Local Authorities

The London VRU should move towards a commissioning **model** that is conductive to the VRU's broader strategic commissioning **approach,** which is long-term, learning-oriented, relational and focussed on embedding collaborative models of practice.

This model should explicitly support youth work providers to share learning, shape delivery, and contribute to the long-term development of the service. Setting this precedent in terms of a relational commissioning model could have a broader impact beyond London, and likely beyond HBYW. The model could help shift competitive dynamics within the VCS sector that limit trust and openness, and instead foster a shared commitment to quality, outcomes, and learning.

Embedding collaboration into the commissioning structure would reinforce accountability – across youth work providers, hospitals, local authorities – by clarifying roles, expectations and the conditions required for effective delivery. It would also allow learning partners to operate more effectively and inform service improvement in real time.

Recommendation 5: Integrate contextual safeguarding approaches and youth work expertise into multi-agency safeguarding forums

Relevant partner(s): NHS Trusts/ICBs, Local Authorities, Youth Work Providers, VRU

Hospital-based youth work practitioners bring contextual safeguarding expertise, rooted in their frontline experience across multiple settings, including hospital environments, statutory contexts and the communities where young people live.

We recommend adapting existing multi-agency safeguarding meetings hosted by either the hospital or the local authority (e.g., discharge planning meetings) so that they intentionally embed contextual safeguarding principles, including assessing the wider extrafamilial risks young people face outside the home including in their schools, neighbourhoods, and online.

With support from the VRU, up to three hospital pilot sites, where youth work providers have strong relationships with key safeguarding partners, would co-develop protocols and meeting structures, drawing upon learning from innovation such as the

Risk Outside the Home (ROTH) pathway[16] and the Swansea CMET Panel[17]. These pilots would aim to broaden safeguarding conversations to include community-based threats such as risks encountered on the way to and from school or within local peer networks. HBYW practitioners would be involved in shaping the design and purpose of these pilots given their insights into local peer dynamics and community contexts.

The VRU would convene professionals and practitioners across the pilot sites regularly to support peer learning and continuous refinement of practice. Research highlights the importance of reflective professional spaces that offer emotional support and peer learning as essential for sustaining culture change.[18] Learnings from the pilots could also be incorporated into the Level 3 Safeguarding training that is mandatory for all clinical staff.

If successful, this model can be scaled to other hospital sites and adapted to local authority multi-agency forums, supporting a wider shift toward embedding contextual safeguarding as a core approach across the systems of support for young people.

Recommendation 6: Use peer-to-peer learning to build core skills across the workforce, starting with system navigation

Relevant Partner(s): Youth Work Providers

Peer-to-peer learning should be embedded as a central approach to workforce development across youth work provider organisations. Practitioners bring deep knowledge of how to engage young people affected by violence, and this insight should be actively surfaced and shared across teams through short, peer-led sessions. These can spotlight specific areas of practice – such as bedside engagement, phone-based communication, or navigating multi-agency meetings – and help build a reflective, practitioner-led learning culture.

An early and urgent focus for this model should be system navigation. Understanding how to work across hospital settings, safeguarding processes, and statutory pathways is essential to how practitioners advocate for young people, which can be a steep learning curve for newly recruited practitioners. Youth work providers should treat this as a defined area of practice, ensuring new and existing staff are supported to build confidence through structured peer learning, alongside more formal training on complex needs such as SEND or mental health.

[16] Contextual Safeguarding, (2024). Risk Outside of the Home Child Protection Pathways: Phase 2 Pilots.
[17] Liverpool John Moores University (2024) Violence prevention in Wales: Swansea case studies report. Available at: https://www.violencepreventionwales.co.uk/cms-assets/research/LJMU_FINAL-VPU-Swansea-case-studies-final-report-August-2024_ENG.pdf (Accessed: 23 June 2025).
[18] Rachel Owens, (2024). Sustaining Social Work: Practitioner experiences of Contextual Safeguarding.

Recommendation 7: Develop system-level outcome measures to assess genuine adoption of the public health approach

Relevant Partner(s): VRUs

Hospital-based youth work is a clear example of the public health approach to violence reduction in action. However, the service's success in an area is dependent on whether the public health approach has been truly embedded.

To move beyond surface-level changes, VRUs across the country should work together to develop practical, system-level outcome measures that help local areas assess whether they're genuinely adopting a public health approach. These outcomes should look at how well different partners – including voluntary and community organisations – are working together and tackling the root causes of violence. They should measure progress at a system-level, rather than simply focussing only on the outcomes of young people. Individual outcomes for young people do not necessarily reflect whether fundamental blockers in the system have been challenged and place responsibility for those outcomes almost entirely on service youth work providers.

Examples of prospective system-level outcomes in relation to the public health approach might include: comprehensive data-sharing agreements being in place; pooled funding arrangements that support joint-commissioning; upwards trending investment in early intervention and community-based services; routine and timely follow-up support for young people discharged from hospital; high levels of trauma-informed and culturally competent training across frontline staff; and active involvement of community and voluntary sector organisations and young people in decision-making about support for young people.

Recommendation 8: Codify and champion positive police-practitioner-young person relationships

Relevant Partner(s): Police, VRUs, NHS Trusts / ICBs, Youth Work Providers

The HBYW service is shaped by how police see and treat both the young people and the practitioners. On the latter, it's crucial to highlight that practitioners often sit in a unique, in-between space: they're a trusted link between young people and the police. Because of the trust they hold with young people, they can help police look beyond surface impressions and understand the real risks and pressures those young people are facing. At the same time, they can help young people feel more seen and heard in any interactions with police, moving things away from conflict and towards genuine support.

This dual role offers real value for police: providing context officers may not otherwise access and helping to de-escalate situations that might otherwise escalate. Yet this contribution isn't always recognised or utilised in practice.

The VRU, trusts and the police should document and promote effective relationship-building approaches, like those developed by the such as the Royal London Hospital Police Trauma Support Team (TST). The Police TST has demonstrated how rapid,

joined-up support can be delivered when police input is needed – for example, in re-housing applications where safety is a concern.

Stronger partnerships between the HBYW service and the police enable holistic support for young people and foster safer, more constructive engagement between young people, practitioners and police.

Recommendation 9: Establish a cross-site learning forum for hospital leads and commissioners nationally

Relevant Partner(s): VRUs, NHS Trusts / ICBs, Youth Work Providers

Hospital leads and youth work providers should convene every four months in a structured, national forum managed by London VRU or collaboratively by multiple VRUs to exchange learning and ideas on what's really enabling HBYW to thrive. This should be a space to address practical factors like honorary contracts and data access but also explore what it means for a hospital to fully embed the service. These should build on similar precedents such as the Redthread HIVE conferences which have taken place in the past.

The forum would cultivate spaces for open reflection and sharing about what's working and what isn't and help to build a shared sense of what strong practice looks like across the system. This could mean exploring how practitioners could work across sites when there are staffing constraints. Other agenda items could be demonstrating the value of the service to clinical teams or helping hospitals see HBYW as part of their core safeguarding processes.

The aim is to move beyond site-specific frustrations and start to build a national picture of what it takes to embed HBYW, while ensuring that the sites take ownership. It's about pooling the good practice that already exists, testing out new ideas together, and making sure those insights are fed into local practice and national conversations. Over time, the forum could also be expanded to include other key stakeholders – such as LA, children's social care or community safety leads – to ensure learning is shared about what's working across the full pathway, from hospital to community support.

Recommendation 10: Improve data collection, quality and infrastructure to demonstrate the full impact of the service

Relevant Partners(s): VRUs, Youth Work Providers, NHS Trusts / ICBs

Youth work providers should ensure that they are collecting high quality data that reflects the full scope and value of hospital-based youth work. This includes how practitioners build trust with young people, reduce risk, and support access to services across health, social care, and community settings. It should also capture their role in safeguarding and their influence on hospital decision-making. This kind of data is essential for demonstrating the service's contribution to wider system goals.

VRUs should set clear expectations around data requirements during commissioning. These requirements should support service development and help build a credible evidence base that strengthens the case for continued investment. Data should also help practitioners communicate their impact to hospital staff and other professionals, building shared understanding and support.

For long-term evaluation, linking provider-held data with health datasets such as Emergency Care Data Set (ECDS) data is essential. While this data is accessed by evaluators, not providers, the infrastructure to enable this linkage must be in place to continue to grow the evidence base around HBYW.

Recommendation 11: Reframe and rebrand the HBYW practitioner role

Relevant Partner(s): VRUs and Youth Work Providers

VRUs and youth work providers across the country should work together to reframe how the HBYW practitioner role is understood inside and outside the hospital. This is about telling a clearer, stronger story about what these practitioners do. This is a specialised role that's deeply rooted in trauma-informed practice and about supporting young people to navigate complex systems, while advocating for and navigating the systems themselves.

A key part of this should focus on public-facing communications: showing practitioners' unique expertise and why it matters. It's also about how other professionals – like clinical staff, safeguarding leads, or statutory professional – understand the unique expertise and distinct value that HBYW practitioners offer.

The aim is to position the practitioner role as essential to system-wide early intervention and prevention. A clearer story and consistent messaging about the role will help build understanding, respect, and support for these practitioners across the system as core partners in safeguarding and violence reduction – and make it easier for them to have greater impact in supporting young people to thrive.

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