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West Midlands Violence Reduction Partnership Evaluation

Teachable Moments in Accident and Emergency: St Giles

Evaluation of Data Quality and Outcomes

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WEST MIDLANDS VIOLENCE REDUCTION PARTNERSHIP

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1.0 Executive Summary

St Giles has been commissioned by the West Midlands Violence Reduction Partnership (WMVRP) since 2020 to deliver the Teachable Moments intervention in Accident & Emergency (A&E) settings across the Black Country and Coventry. The programme offers immediate, trauma-informed support and follow-up mentoring to young people attending A&E as a result of violence, exploitation, or gang-related harm. It aims to improve emotional wellbeing, reduce risk, and increase engagement in positive activities such as education, training, or employment.

This report forms part of a series of data quality and outcomes reviews undertaken on programmes commissioned by the WMVRP. The aim of this evaluation was to access the quarterly monitoring returns providers share with the WMVRP to: 1. Review the type, quality, and quantity of data collected by providers; 2. Process, clean, and analyse the data to identify evidence of impact. The evaluation draws on data submitted by the programme provider, St. Giles, to the WMVRP collected during April to September 2024.

Data were provided for 179 young people. The dataset includes demographic information, referral pathways, presenting needs, and recorded outcomes across key domains. Most referrals were made by health professionals, and most participants were boys and young men, with common issues including peer relationship difficulties, violence, and emotional distress.

While the programme engaged its intended demographic and some positive changes were observed - such as reduced A&E reattendance and increased confidence - limited progress was recorded in areas such as education, employment, and relationships. Incomplete data, inconsistent outcome reporting, and limited engagement with other services restricted the ability to assess overall programme impact.

Key recommendations include improving the completeness and quality of data, increasing in-person engagement where appropriate, and ensuring outcome measures are better aligned with the presenting needs of participants. Despite these challenges, Teachable Moments continues to provide timely and targeted support to young people during critical intervention windows, contributing to the WMVRP's broader public health approach to preventing youth violence.

KEY FINDINGS
The St Giles Teachable Moments A&E intervention continues to engage young people at risk of violence and exploitation. However, limitations in outcome reporting and the short-term nature of engagement restrict the ability to draw firm conclusions about overall impact. Key findings are as follows: • **Demographic engagement:** The programme primarily supported boys and young men aged 13–17, with most referrals originating from Russell's Hall (Dudley) and Wolverhampton hospitals. As expected in hospital settings, most referrals were made by health professionals. • **Nature of presentations and referrals:** Assault-related injuries, including fist and blunt object attacks, were the most common reason for A&E attendance. Violence and mental

health were the leading causes for referral, reflecting the complex vulnerabilities of participants.

- **Presenting needs and service gaps:** Peer relationships and emotional wellbeing were the most frequently recorded presenting needs, though many cases were classified as "other". Nearly half of participants had no prior involvement with statutory services, indicating potential gaps in early identification and support.
- **Limited engagement with wider services:** Most participants had no contact with multiple services, suggesting minimal multi-agency involvement. There is a complex risk and need profile for those in contact with the intervention, likely to require additional support.
- **Short-term outcomes and limited progress:** While some improvements were noted in confidence, wellbeing, and reduced A&E re-attendance, outcome data showed minimal progress in education, employment, relationships, and police contact. A high proportion of cases were marked as "not applicable", suggesting limited reach or relevance of some indicators.
- **Data quality and reporting challenges:** Large sections of outcome data were missing, inconsistent, or categorised under generic headings. This limited the ability to draw clear conclusions and assess sustained impact.

RECOMMENDATIONS

Recommendations for St Giles

- **Improve data accuracy and completeness:** Work with revised template from the WMVRP data team that will standardise the use of outcome categories. Avoid marking large numbers of cases as ‘not applicable’ when not assessed/not recorded/unknown might be more appropriate. Provide clear definitions to ensure consistent reporting across quarters.
- **Tailor interventions to specific needs:** Align outcome tracking more closely with presenting needs to better assess progress and relevance of interventions across different domains, such as education, relationships, and risk reduction.
- **Consider further options for onward referral.** There is a complex risk and need profile for those in contact with the intervention, likely to require additional support. However, the current data suggest minimal multi-agency involvement

Recommendations for the WMVRP

- **Support improvements in outcome tracking:** Work with the provider to refine success scales and encourage clear documentation of change over time, including structured follow-up where feasible.
- **Promote consistent data frameworks:** Ensure alignment of monitoring templates with the Theory of Change and reporting requirements, supporting providers in embedding these into practice.
- **Review outcome measures for relevance:** Consider revising or consolidating indicators where high proportions are marked as ‘not applicable’, to ensure measures reflect meaningful change for the target population.

2.0 Introduction and Research Question

2.1 Background and Context

The West Midlands Violence Reduction Partnership (WMVRP) was established in 2019 to address violent crime through a public health approach, focusing on prevention, intervention, and systemic change. Funded by the Home Office and local government bodies, the WMVRP commissions a range of providers, including community organisations, to tackle the complex social and economic issues that contribute to violence, gang involvement, and other forms of criminality. The WMVRP prioritises understanding the factors that lead to violence, identifying risk and protective factors, and implementing evidence-based strategies that harness community resources. From the outset, evaluation has been embedded within the WMVRP's operations to refine and sustain its activities and approach. Building upon evaluations conducted since 2020, this evaluation report forms part of a series of evaluations undertaken on programmes commissioned by the WMVRP. One such initiative is the Teachable Moments project, which since being commissioned by the WMVRP in 2020 has aimed to support children and young people presenting at the Accident and Emergency (A&E) departments of hospitals in Coventry and Wolverhampton, as well as the Major Trauma Centre (MTC), due to incidents of youth violence, exploitation, or gang and county lines involvement. In 2021, the Teachable Moments A&E project expanded to Dudley

2.2 A&E Teachable Moments

The St Giles A&E Teachable Moments intervention supports children and young people presenting to emergency departments due to youth violence, exploitation, or gang-related activity. The intervention adopts a structured approach, offering one-to-one crisis support within A&E, followed by structured mentoring, safety planning, and multi-agency collaboration to address key risks. Support focuses on violence reduction, emotional resilience, and engagement in education, training, or employment. Typically, participants engage with trauma-informed caseworkers across a series of touchpoints, beginning with an initial assessment followed by regular mentoring interactions. A midpoint review enables caseworkers and participants to evaluate progress and refine support strategies as needed, ensuring the intervention remains relevant to their specific requirements. This flexible, data-driven approach allows St Giles Trust to adapt its methods dynamically while remaining focused on delivering meaningful and lasting outcomes for the children and young people it supports.

The Teachable Moments project aims to achieve the following outcomes for the children and young people it engages with:

- Enhanced self-esteem and confidence.
- Strengthened positive relationships with family and peers.
- Greater engagement with education and training opportunities.
- Reduced involvement in criminal activities.
- Lower risk of harm.
- Fewer episodes of going missing.
- Reduced vulnerability to gang involvement.

2.3 Previous Evaluation Work

Previous evaluations of the Teachable Moments programme, conducted by the University of Wolverhampton, have focused on assessing intervention effectiveness and refining programme methodologies. In 2020/21, a detailed review of data collection methods and outcomes was conducted, resulting in eight recommendations to improve evaluation accuracy. Key suggestions included documenting the duration and specifics of each intervention, implementing random sampling for comparison, and incorporating additional data on youth justice involvement. These adjustments aimed to enable a clearer picture of how Teachable Moments contributes to reducing youth violence and improving resilience among participants (Adams-Quackenbush and Caulfield, 2021[1]).

The 2021/22 evaluation, which extended to include the Dudley hospital site, used a mixed-methods approach that combined quantitative and qualitative data. Findings indicated that programme participants showed significant improvements in self-esteem, relationship quality, and overall well-being, though some areas, such as preventing re-attendance at A&E, had mixed results. Additionally, the evaluation highlighted logistical and funding challenges, stressing the need for secure, long-term funding to maintain consistent support without disruptions. Recommendations from this report included a six-month setup phase for programmes in new settings to ensure programme integration within hospital settings and a standardised approach to recording outcomes data, making it possible to analyse impact more comprehensively (Adams-Quackenbush, Harewood, Sojka, Wilson, and Caulfield, 2022[2]).

In 2022, the evaluation team assisted St. Giles in developing a Theory of Change model to refine programme objectives and outcomes. This model outlined specific goals and enabled more effective tracking of intermediate achievements, such as reduced gang association and substance misuse. Despite these advancements, challenges have remained, particularly regarding participant engagement and data consistency. For instance, inconsistent use of unique identifiers across data quarters and substantial missing data have hindered the ability to conduct a fully robust impact analysis. Moving forward, these evaluation insights should be used to inform continued improvements in the programme's implementation and effectiveness, ultimately supporting WMVRP's objectives of reducing youth violence and promoting safer communities (Garner and Caulfield, 2023).

RECOMMENDATIONS FROM THE MOST RECENT EVALUATION REPORT [3]
The 2022/23 evaluation of the Teachable Moments initiative identified several recommendations to improve the effectiveness, data quality, and sustainability of the intervention. These include: 1. **Map Outcomes to Presenting Needs:** Align outcomes with specific presenting needs to enable more focused and participant-specific analyses of intervention effectiveness. 2. **Refine Question Design:** Avoid adding new options to existing questions at different time points. Instead, introduce additional questions to address new variables as needed.

[1] The Project Level Evaluation: Commissioned Interventions and Place-Based Pilots (2021) | Data and Insight Hub
[2] Evaluation of WMVRU Teachable Moments – Russells Hall (2022) | Data and Insight Hub
[3] See Garner and Caulfield (2023) Evaluation of the WMVRP Teachable Moments St Giles (2023) | Data and Insight Hub

3. **Emphasise Longitudinal Data Collection:** Ensure unique IDs are not reused across quarters to build robust longitudinal data. This will enable better assessment of the effectiveness of sustained service contact.
4. **Collaborate with Evaluation Teams:** Continue working with the evaluation team to refine data collection methods and explore opportunities to compare data with other datasets, enhancing understanding of the intervention's effectiveness

2.4 Review of Data Quality and Theory of Change

In 2022, the evaluation team supported various providers commissioned by the WMVRP with the development of a programme specific Theory of Change (mandated by the Home Office as part of their commissioning contract). The ToC is essential for service providers as it provides a structured framework linking activities to expected outcomes, ensuring clarity in programme objectives. By outlining the pathways for achieving impact, a ToC assists in supporting the collection of relevant, data aligned with specific goals, enabling evaluation and continuous improvement of the service. In October and November of 2023, the evaluation team facilitated data quality workshops to assist providers with the reassessment of their Theory of Change and to re-evaluate their data monitoring templates to ensure any changes to delivery or data monitoring were captured.

The workshops with providers and the WMVRP data team supported the creation of updated monitoring templates that capture programme-specific outcomes that align with each programme's Theory of Change. Each monitoring form was tailored to support evaluation, and the evaluation team developed ways in which programmes' outcomes could be quantified and transferred into measurable data. The evaluation team engaged with providers to identify and refine programme inputs, activities, outputs and outcomes, and the appropriate measures and methods to assess their achievement. Where appropriate, the monitoring templates were aligned with providers' existing outcome trackers or new case management systems. The development of the updated templates was guided by the recommendations provided in the data quality short reports completed by the evaluation team in 2022/23. The monitoring templates were finalised with approval from providers and shared for completion for the end of Quarter 1 in the financial year 2024/25.

To avoid incomplete data sets, the finalised templates for each provider were embedded into the relevant contract, with clear expectations that the templates cannot be amended without prior consultation with the WMVRP data team or evaluation team input. Providers were informed that any returns sent on incorrect templates would not be approved.

2.5 Research Question

The overall goal of the programme-level element of evaluation work is to work with providers to understand their contribution to the overall WMVRP objectives, and to support providers in gathering robust data to evidence impact.

Evaluation of impact explores whether changes in outcomes are happening because of the programme or intervention. The aim of this evaluation was to access the quarterly monitoring returns providers share with the WMVRP to:

1. Review the type, quality, and quantity of data collected by providers.

2. Process, clean, and analyse the data to identify evidence of impact.

3.0 Methodology

3.1 Design and Procedure

Data captured demographic details, presenting needs, referral reasons, and intervention outcomes, providing valuable insights into the impact of the programme. The evaluation examines the effectiveness of the intervention in reducing A&E reattendance, enhancing protective factors, and supporting long-term behavioural change, aligning with the WMVRP's public health approach to violence prevention.

3.2 Participants

The dataset included anonymised information on 179 participants who engaged with the Teachable Moments intervention following an A&E presentation. Participants ranged in age from 11 to 25, with the majority referred due to assault-related injuries, criminal exploitation, or concerns around gang involvement.

3.3 Data Analysis

The data were organised into structured Excel spreadsheets before being imported into Jamovi for analysis. The dataset comprised anonymised demographic information, referral pathways, intervention engagement records, and outcome measures. Prior to conducting the analysis, data cleaning processes were carried out to maintain accuracy and uniformity. Cases with incomplete demographic data were flagged, and missing values were reviewed to determine whether they followed a random pattern or indicated disengagement. Inconsistent entries were removed, and frequency counts were conducted to identify gaps in demographic reporting and intervention records. The dataset was then analysed in Jamovi using descriptive statistics and frequency analysis to explore participant characteristics, service engagement, and intervention outcomes. The distribution of gender, age, and ethnicity was examined alongside referral pathways. Frequency counts and percentages were generated for each category to identify patterns in intervention uptake and service engagement trends.

3.4 Ethical Approval

Ethics approval was originally granted by the University of Wolverhampton Ethics Committee in 2020 and the most recent update was approved on 4th October 2024. Mirror documents are held by Edge Hill University as the collaborative partner.

4.0 Findings

This section provides an overview of participant demographics, referral pathways, and engagement across the five hospital sites involved in the intervention. It explores how young people entered the service, the reasons for their A&E attendance, and their levels of contact with other services. The analysis highlights the characteristics of those supported and the operational reach of the programme during the reporting period.

4.1 Demographics and Referrals

Gender Distribution

The majority of individuals in the study are male (118, 65.9%), while female participants make up 61 (34.1%) of the total. This indicates that the intervention predominantly engages with male participants, aligning with wider trends where young males are statistically more likely to be involved in or impacted by youth violence and exploitation.

Frequencies of Gender

Gender	Numbers	% of Total
Female	61	34.1 %
Male	118	65.9 %

Age Distribution

The age distribution data highlights that the largest group of participants are aged 15, totalling 30 (16.8%), followed by 17-year-olds at 22 (12.3%) and 14-year-olds at 16 (8.9%). A smaller number fall into younger age brackets, with 11-year-olds at 2 (1.1%), while older participants, such as 20-year-olds at 8 (4.5%) and 25-year-olds at 8 (4.5%), are present in lower proportions. This concentration in mid-teenage years suggests the programme is engaging individuals at a critical developmental stage when risk factors and intervention opportunities are heightened.

Frequencies of Age

Age	Numbers	% of Total
11	2	1.1 %
12	11	6.1 %
13	14	7.8 %
14	16	8.9 %
15	30	16.8 %
16	14	7.8 %
17	22	12.3 %
18	10	5.6 %
19	9	5.0 %
20	8	4.5 %
21	4	2.2 %
22	11	6.1 %
23	11	6.1 %
24	8	4.5 %
25	8	4.5 %
27	1	0.6 %

Ethnicity Breakdown

The ethnicity data indicates a diverse range of participants. The majority identified as White British, accounting for 113 (63.1%) of the total. Other ethnic groups represented include Asian/Asian

British/Other at 12 (6.7%), Black/Black British/Caribbean at 7 (3.9%), and Indian at 5 (2.8%). A significant proportion, 21 (11.7%), had no ethnicity recorded, limiting the ability to fully assess the demographic reach and inclusivity of the programme.

Frequencies of Ethnicity

Ethnicity	Numbers	% of Total
Asian/Asian British/Other	12	6.7 %
Black/ Black British/Caribbean	7	3.9 %
Indian	5	2.8 %
Mixed/ White & Black Caribbean	7	3.9 %
Mixed/White & Asian	2	1.1 %
Not recorded/Given	21	11.7 %
Other - Not listed	9	5.0 %
Pakistani	3	1.7 %
White/ English/ Welsh/ Scottish/ N.Irish/ British	113	63.1 %

Local Authority area of residence

The majority of participants resided in Dudley 70 (39.1%), and Wolverhampton 69 (38.5%), together accounting for over three-quarters of cases. Lower proportions of participants were recorded in Coventry (16, 8.9%), and Birmingham 14 (7.8%), while Sandwell 9 (5.0%), had the smallest recorded number of cases. One case (0.6%) had no local authority data reported. These figures reflect regional variations in youth violence and referral pathways, with Dudley and Wolverhampton emerging as key areas where the intervention is most frequently utilised.

Frequencies of Local Authority area of residence

LA area of residence	Numbers	% of Total
Birmingham	14	7.8 %
Coventry	16	8.9 %
Dudley	70	39.1 %
Non Reported Data	1	0.6 %
Sandwell	9	5.0 %
Wolverhampton	69	38.5 %

Hospital Site

The distribution of intervention cases across hospital sites highlights variations in referral rates. The highest proportion of participants were referred from Russell's Hall Hospital, 74 (41.3%), followed closely by Wolverhampton Hospital, 68 (38.0%). Coventry Hospital accounted for 16 (8.9%) of referrals, while Sandwell Hospital, 13 (7.3%), and Birmingham City Hospital, 8 (4.5%), had the lowest numbers. These figures suggest that some hospitals serve areas with higher levels of youth violence and exploitation or may have stronger referral mechanisms in place.

Frequencies of Site

Site	Numbers	% of Total
Birmingham City	8	4.5 %
Coventry Hospital	16	8.9 %
Russell's Hall Hospital	74	41.3 %
Sandwell Hospital	13	7.3 %
Wolverhampton Hospital	68	38.0 %

Referrals

The data indicate that referrals were overwhelmingly made by health professionals (178, 99.4%), with only 1 (0.6%) referral coming from another source. This underscores the central role of hospital staff in identifying and referring children and young people in need of support.

Frequencies of Referral source

Referral from	Numbers	% of Total
Health Professional	178	99.4 %
Other	1	0.6 %

Referral Type

The majority of referrals were initiated through clinical coding 105 (58.7%), indicating that hospital records play a significant role in identifying eligible participants. Other referral methods included referral forms via email (26, 14.5%), and safeguarding referrals 26 (14.5%), demonstrating the involvement of designated safeguarding teams. Ward rounds accounted for 20 (11.2%) of referrals, while direct calls and bleeps were used in only 1 case each (0.6%). The dominance of clinical coding suggests that referrals are primarily data-driven rather than based on immediate, direct identification by hospital staff.

Frequencies of Referral type

Referral type	Numbers	% of Total
Bleep	1	0.6 %
Call	1	0.6 %
Clinical Coding	105	58.7 %
Referral form - Email	26	14.5 %
Safeguarding	26	14.5 %
Ward rounds	20	11.2 %

Reason for Hospital Presentation

The, 124 (69.3%), highlighting that physical altercations were the most common cause of injury. Self-harm (18, 10.1%), was also a significant factor, indicating mental health concerns among individuals seeking emergency care. Stabbings accounted for 7 individuals (3.9%), showing that weapon-related violence remains a concern. Other reasons included fights (7, 3.9%), assaults with a sharp object (4, 2.2%), and blunt object assaults (3, 1.7%), suggesting varied forms of physical aggression. Suicidality (3, 1.7%), and overdose (2, 1.1%), further emphasise the role of mental health in hospital admissions. Other causes included assault by pushing (3, 1.7%), vehicle-related incidents (3, 1.7%), and sexual assault (1, 0.6%). The prevalence of both violent injuries and mental health crises underscores the need for integrated support services addressing both physical safety and psychological well-being.

Frequencies of Reason for hospital presentation (e.g. stabbing)

Reason for hospital presentation (e.g. stabbing)	Numbers	% of Total
Assault - Blunt Object	3	1.7 %
Assault - Fist used as weapon	124	69.3 %
Assault - Other bladed or sharp object	4	2.2 %
Assault - Pushed	3	1.7 %
Assault - Sexual Assault	1	0.6 %
Assault - Stabbed	7	3.9 %
Assault - Vehicle used as weapon	1	0.6 %
Drug use/illegal activity	1	0.6 %
Fight	7	3.9 %
Mental Health - Overdose	2	1.1 %
Mental Health - Self Harm	18	10.1 %
Mental Health - Suicidality	3	1.7 %
Non Reported Data	1	0.6 %
Other	1	0.6 %
Vehicle Incident	3	1.7 %

Reasons for Referral

The data indicates that the majority of referrals, 133 individuals (74.3%), were related to violence (other), suggesting that general violence remains the predominant reason for intervention. Mental health concerns (25 individuals, 14.0%) were the second most common reason, highlighting the need for psychological support among participants. A smaller proportion of referrals were due to knife crime (3.9%), criminal exploitation (2.8%), and domestic abuse/VAWG (2.8%), reflecting serious safeguarding concerns. Three individuals (1.7%) were classified as "other", while one individual (0.6%) was not reported. These figures suggest that while violence is the primary concern, mental health and exploitation also require targeted interventions.

Frequencies of Reason for referral

Reason for referral	Numbers	% of Total
Domestic abuse/VAWG	5	2.8 %
Exploitation – Criminal/Gangs/County Lines	5	2.8 %
Knife crime	7	3.9 %
Mental health	25	14.0 %
Non Reported Data	1	0.6 %
Other	3	1.7 %
Violence – other	133	74.3 %

4.2 Presenting Needs and Service Involvement

This section outlines the primary needs identified at the point of referral, with peer relationships and emotional wellbeing featuring prominently. Issues such as self-harm, family conflict, and substance misuse were also recorded, albeit less frequently. The data reflects the varied and complex challenges faced by participants during crisis intervention.

Presenting Needs

The data shows that 87 individuals (48.6%) were categorised under "other" needs, indicating a broad range of issues not explicitly listed. Peer relationship difficulties (59 cases, 33.0%) were a significant concern, suggesting that social challenges play a key role in individuals' experiences. Self-harm (9.5%) and family relationship issues (6.1%) were also present, reflecting emotional distress and family instability. Alcohol or substance misuse (2.8%) was less frequently reported, though it remains a critical concern for those affected.

Frequencies of Presenting need(s)

Presenting need(s)	Numbers	% of Total
Alcohol / Substance misuse	5	2.8 %
Other	87	48.6 %
Relationships (family)	11	6.1 %
Relationships (peer)	59	33.0 %
Self harm	17	9.5 %

Pre-existing statutory service involvement

The data indicate that nearly half of participants, 88 (49.2%), were not known to any other statutory services before engaging with the intervention. Among those with previous service involvement, 60

(33.5%) had contact with education services, making this the most common statutory link. Police involvement was recorded for 17 (9.5%), while 7 (3.9%) were known to social care. Smaller proportions had prior engagement with CAMHS 3 (1.7%), community or voluntary services 3 (1.7%), and health services 1 (0.6%).

Known to other statutory services?

Known to other statutory services?	Numbers	% of Total
CAMHS	3	1.7 %
Education	60	33.5 %
Health	1	0.6 %
No	88	49.2 %
Other community/voluntary	3	1.7 %
Police	17	9.5 %
Social Care	7	3.9 %

Other service involvement

The data reveals that 161 individuals (89.9%) did not engage with multiple services, suggesting a potential lack of multi-agency involvement. Among those who did access additional support, 8 individuals (4.5%) interacted with the police, while 4 (2.2%) engaged with community/voluntary organisations. Only 3 (1.7%) accessed education services, 2 (1.1%) received social care, and 1 individual (0.6%) engaged with health services.

Frequencies of If multiple which services?

If multiple which services?	Numbers	% of Total
Education	3	1.7 %
Health	1	0.6 %
No	161	89.9 %
Other community/voluntary	4	2.2 %
Police	8	4.5 %
Social Care	2	1.1 %

Accommodation status

The majority of participants (100 (55.9%), lived with their parents, indicating a level of family stability. However, a significant proportion 67 37.4%), had no recorded accommodation data, limiting the ability to assess housing-related vulnerabilities. Smaller numbers were living in local authority care (3, (1.7%), supported accommodation such as YMCA 2 (1.1%), or on their own 3 (1.7%). A small

proportion were recorded as living with other family members 2 (1.1%), in shared accommodation 1, 0.6%), or in prison 1 (0.6%).

Frequencies of Accommodation status

Accommodation status	Numbers	% of Total
Lives in LA Care	3	1.7 %
Lives in supported accommodation e.g. YMCA	2	1.1 %
Lives on own	3	1.7 %
Lives with other family members	2	1.1 %
Lives with parents	100	55.9 %
Not provided	67	37.4 %
Prison	1	0.6 %
Shares with others	1	0.6 %

Education and Employment Status

A significant proportion of participants 103 (57.5%), had no recorded education or employment status, making it difficult to evaluate intervention outcomes in these areas. Among those with available data, 71 (39.7%) were engaged in formal education, such as school, pupil referral units (PRUs), college, or university. A smaller number 4 (2.2%), were not in education, employment, or training (NEET), suggesting that some children and young people may face barriers to accessing structured learning or work opportunities. One participant (0.6%) had no reported data.

Frequencies of Education Employment Status

Education Employment Status	Numbers	% of Total
Attends school, PRU, College or University	71	39.7 %
Non Reported Data	1	0.6 %
Not in Education, Employment or training	4	2.2 %
Not recorded/given	103	57.5 %

Victim known to perpetrator

Half of the victims 65 (50.4%), did not know the perpetrator, while 40 (31.0%) knew them but did not specify the relationship. A small number of cases involved family members (2, 1.6%), and partners (5, 3.9%). Additionally, 6 (4.7%) incidents were related to school, and 8 (6.2%) were classified as "other" relationships. Some cases 2 (1.6%), were not reported, while 1 (0.8%) victim declined to provide relationship details.

Frequencies of Does the victim know the perpetrator?

Does the victim know the perpetrator? (Gang related, family member, partner, unkown assailant)	Counts	% of Total
Family Member	2	1.6 %
Known to victim declined to give relationship details	1	0.8 %
No	65	50.4 %
Other	8	6.2 %
Partner	5	3.9 %
School related	6	4.7 %
Non Reported Data	2	1.6 %
Yes	40	31.0 %

Recent A&E referrals

The vast majority of individuals (172, 96.1%), had not attended A&E due to an assault, fight, or sexual assault in the past five years. However, 3 (1.7%) had attended, while 3 (1.7%) had records that were either unknown or inaccessible. One case, 1 (0.6%), was not reported. This data highlights that while the number of individuals needing emergency medical attention for assault is low, the fact that some attend repeatedly may indicate ongoing risk or inadequate support.

Frequencies of 'Has the young person attended A&E in the last 5 years as a result of an assault, fight or sexual assault?'

Has the young person attended A&E in the last 5 years as a result of an assault, fight or sexual assault?	Numbers	% of Total
No	172	96.1 %
Unknown/Unable to access records	3	1.7 %
Non Reported Data	1	0.6 %
Yes	3	1.7 %

Method of contact

Most interactions were conducted over the phone, with 122 (68.2%) handled via telephone calls and 47 (26.3%) through calls to parents. Face-to-face interactions were significantly less frequent, accounting for 8 (4.5%) of cases. A small number (2, 1.1%), were not reported. The high reliance on phone communication suggests accessibility and efficiency, but the low number of face-to-face meetings may impact the depth of engagement and support provided.

Frequencies of Method of contact (e.g. ward visit)

Method of contact (e.g. ward visit)	Numbers	% of Total
Telephone call	122	68.2 %
Telephone call to parent	47	26.3 %
Non Reported Data	2	1.1 %
face to face	8	4.5 %

Reducing risk

A majority of individuals, 127 (70.9%), showed no change in risk levels, while some reduction was seen in 33 (18.4%) cases, and a significant reduction was observed in 7 (3.9%) cases. Only 1 (0.6%) improved their ability to manage risk. A small proportion, 11 (6.1%), were not reported. Despite interventions, most individuals did not experience a decrease in risk, highlighting the need for more effective strategies to help reduce vulnerability.

Frequencies of Reducing risk - success scale

Reducing risk - success scale	Numbers	% of Total
Improved ability to manage risk	1	0.6 %
No change	127	70.9 %
Risk has reduced significantly	7	3.9 %
Risk has reduced somewhat	33	18.4 %
Non Reported Data	11	6.1 %

4.3 Wellbeing Outcomes

This section explores recorded changes in participants' wellbeing following engagement with the intervention. It includes data on physical health, confidence, and understanding of risks related to exploitation. Whilst some improvements were observed, the findings suggest there is scope for broader and more consistent impact.

Increased understanding of their issues and risks around Child Criminal Exploitation (CCE)/ Child Sexual Exploitation (CSE) success scale

Most individuals 167 (93.8%), showed no change in their understanding of risks related to child criminal and sexual exploitation. Only 2 (1.1%) reported an increased understanding, while 9 (5.1%) were not reported. This indicates that current awareness efforts may not be sufficiently impactful, potentially leaving children and young people at continued risk of exploitation. Enhancing engagement through real-life survivor stories, interactive workshops, and age-appropriate educational materials may help improve awareness and comprehension.

Frequencies of Increased understanding of their issues and risks around CCE/CSE success scale

Increased understanding of their issues and risks around CCE/CSE success scale	Numbers	% of Total
No change	167	93.8 %
Understanding has increased somewhat	2	1.1 %
Non Reported	9	5.1 %

Improved confidence & self-esteem

Confidence remained unchanged for 77 (43.0%) individuals, while some improvement was reported by 22 (12.3%) and significant improvement by 3 (1.7%). A large proportion, 66 (36.9%), was marked as "measure not applicable," and 11 (6.1%) were not reported.

Frequencies of Improved Confidence & Self-Esteem - Success Scale

Improved Confidence & Self-Esteem - Success Scale	Numbers	% of Total
Confidence has Increased Significantly	3	1.7 %
Confidence has Increased Somewhat	22	12.3 %
Measure N/A	66	36.9 %
No Change	77	43.0 %
Non Reported Data	11	6.1 %

Reduction of missing episodes

Most individuals 169 (94.4%), were marked as "measure not applicable," while 10 (5.6%) were not reported. The data suggests that the majority of individuals did not have a history of going missing, but further exploration is needed to understand the patterns of those who do. Identifying triggers for missing episodes, such as family conflict or exploitation risks, could inform early intervention strategies and help prevent future occurrences.

Frequencies of Reduction of missing episodes

Reduction of missing episodes	Numbers	% of Total
Measure n/a	169	94.4 %
Non Reported	10	5.6 %

Frequencies of Health & Wellbeing outcome

Some individuals 28 (15.6%), reported improved physical health and well-being, while a smaller number 4 (2.2%), received support to improve well-being. 1 individual (0.6%) was reported as e encouraged to take up a positive activity, and another 1 individual (0.6%) received support due to a life-threatening situation. The majority 133 (74.3%), were marked as "measure not applicable," and 12 (6.7%) were not reported.

Frequencies of Health & Wellbeing success scale

Health & Wellbeing outcome	Numbers	*% of Total*
Encouraged to take up Positive Activity	1	0.6 %
Improved Physical Health & Wellbeing	28	15.6 %
Measure N/A	133	74.3 %
Support to Improve Well-Being	4	2.2 %
Support with Threat to Life Situation	1	0.6 %
Non Reported Data	12	6.7 %

Frequencies of Health & Wellbeing success scale

Most individuals (136, 76.0%), saw no change in their health and well-being, while 30 (16.8%) reported some improvement and 3 (1.7%) experienced significant progress. Data was not reported for a small proportion 10 (5.6%).

Frequencies of Health & Wellbeing success scale

Health & Wellbeing success scale	Numbers	% of Total
Health/ Wellbeing has Increased Somewhat	30	16.8 %
Health/Wellbeing has Increased Significantly	3	1.7 %
No Change	136	76.0 %
Non Reported Data	10	5.6 %

Education & employment outcome

A large majority 166 (92.7%), were marked as "measure not applicable." A small number 3 (1.7%), were supported to improve attendance or engagement in education or training, while 10 (5.6%) were not reported.

Frequencies of Education & employment outcome

Education & employment outcome	Numbers	% of Total
Measure N/A	166	92.7 %
Supported to Improve Attendance/ Engagement in Education or Training	3	1.7 %
Non Reported Data	10	5.6 %

Education & employment success scale

Most individuals 165 (92.2%), experienced no change in their education or employment outcomes, while 3 (1.7%) saw some improvement and 1 (0.6%) reported significant progress. A small proportion, 10 (5.6%), were not reported. This suggests that while some benefit from support, the majority see little to no impact on their educational or employment status.

Frequencies of Education & employment success scale

Education & employment success scale	Numbers	% of Total
No Change	165	92.2 %
Significant Improvement	1	0.6 %
Some Improvement	3	1.7 %
Non Reported Data	10	5.6 %

Relationships outcome

A significant portion 162 (90.5%), were marked as "measure not applicable." Small numbers of individuals received support for improving family relationships 1 (0.6%), peer relationships (2, 1.1%), peer and family relationships combined (1, 0.6%), and relationships with professionals 2 (1.1%). Another small group 2, (1.1%), fell under "Other," while 9 (5.0%) were not reported. Few individuals

received direct relationship support, which may indicate an unmet need for fostering positive connections.

Frequencies of Relationships outcome

Relationships outcome	Numbers	% of Total
Measure N/A	162	90.5 %
Other	2	1.1 %
Supported to Improve Family Relationships	1	0.6 %
Supported to Improve peer & Family Relationships	1	0.6 %
Supported to Improve Peer Relationships	2	1.1 %
Supported to Improve Relationship with Professionals	2	1.1 %
Non Reported Data	9	5.0 %

Relationships outcome success scale

A large majority (157, 87.7%), saw no change in their relationship outcomes. Some improvement was reported by 12 (6.7%), while significant improvement was seen in only 1 (0.6%) case. A small proportion, 9 (5.0%), were not reported.

Frequencies of Relationships outcome success scale

Relationships outcome success scale	Numbers	% of Total
No Change	157	87.7 %
Significant Improvement	1	0.6 %
Some Improvement	12	6.7 %
Non Reported Data	9	5.0 %

Supported to establish support networks - success scale

More than half 100 (55.9%), saw no change in their support networks, while some improvement was seen in 13 (7.3%) cases, and significant improvement in 1 (0.6%) case. A considerable proportion (56, 31.3%) were marked as "measure not applicable," and 9 (5.0%) were not reported. A lack of improvement in support networks could hinder long-term recovery and stability for these individuals.

Frequencies of Supported to establish support networks - success scale

Supported to establish support networks - success scale	Numbers	% of Total
Measure n/a	56	31.3 %
No Change	100	55.9 %
Significant Improvement in Support Networks	1	0.6 %
Some Improvement in Support Networks	13	7.3 %
Non Reported Data	9	5.0 %

Lifestyle success scale

The data shows that 142 individuals (79.3%) experienced no change in their lifestyle, friendships, or participation in positive activities. However, 25 individuals (14.0%) reported some improvement, while only 2 (1.1%) showed significant progress. A small number 10 (5.6%) had non-reported data.

Frequencies of Lifestyle – more positive friendships/new positive social bonds, positive leisure and sport activities success scale

Lifestyle – more positive friendships/new positive social bonds, positive leisure and sport activities success scale	Numbers	% of Total
No change	142	79.3 %
Significant Improvement in Lifestyle	2	1.1 %
Some Improvement in Lifestyle	25	14.0 %
Non Reported Data	10	5.6 %

Reduced contact with police

The majority 159 (88.8%), saw no change in police contact, while 9 (5.0%) reported an increase, and only 1 (0.6%) experienced a significant reduction. A small proportion 10 (5.6%), were not reported. This suggests that intervention efforts have not significantly influenced interactions with law enforcement.

Frequencies of Reduced contact with police

Reduced contact with police	Numbers	% of Total
Has Increased	9	5.0 %
No Change	159	88.8 %
Significant Reduction	1	0.6 %
Non Reported Data	10	5.6 %

Reduced re-attendance to Emergency Department

A significant proportion 95 (53.1%), showed no change in emergency department attendance. However, 68 (38.0%) had no further attendance, and 3 (1.7%) reported reduced attendance. A small number 2 (1.1%), had repeat visits, while 10 (5.6%) were not reported, and 1 (0.6%) was marked as "N/A."

Frequencies of Reduced re-attendance to Emergency Department

Reduced re-attendance to Emergency Department	Numbers	% of Total
N/A	1	0.6 %
No Change	95	53.1 %
Repeat Attendances	2	1.1 %
Non Reported Data	10	5.6 %
Yes, No Attendance	68	38.0 %
Yes, Reduced Attendance	3	1.7 %

Reduced Alcohol-substance misuse

The data shows that for 162 individuals (97.0%), alcohol or substance misuse was not applicable, meaning it was not a concern for them. However, 3 individuals (1.8%) reported a worsening in their substance use, while 2 (1.2%) saw no change.

Frequencies of Reduced Alcohol-substance misuse

Reduced Alcohol-substance misuse	Numbers	% of Total
Has Worsened	3	1.8 %
No Change	2	1.2 %
N/A	162	97.0 %

5.0 Discussion and Conclusion

The St Giles Teachable Moments A&E intervention continues to engage young people at risk of violence and exploitation. However, limitations in outcome reporting and the short-term nature of engagement restrict the ability to draw firm conclusions about overall impact. Key findings are as follows:

- **Demographic engagement:** The programme primarily supported boys and young men aged 13–17, with most referrals originating from Russell's Hall (Dudley) and Wolverhampton hospitals. Most referrals were made by health professionals, underlining A&E as a crucial intervention point.
- **Nature of presentations and referrals:** Assault-related injuries, including fist and blunt object attacks, were the most common reason for A&E attendance. Violence and mental health were the leading causes for referral, reflecting the complex vulnerabilities of participants.
- **Presenting needs and service gaps:** Peer relationships and emotional wellbeing were the most frequently recorded presenting needs, though many cases were classified as "other". Nearly half of participants had no prior involvement with statutory services, indicating potential gaps in early identification and support.
- **Limited engagement with wider services:** Most participants had no contact with multiple services, suggesting minimal multi-agency involvement.
- **Short-term outcomes and limited progress:** While some improvements were noted in confidence, wellbeing, and reduced A&E re-attendance, outcome data showed minimal progress in education, employment, relationships, and police contact. A high proportion of cases were marked as "not applicable", suggesting limited reach or relevance of some indicators.
- **Data quality and reporting challenges:** Large sections of outcome data were missing, inconsistent, or categorised under generic headings. This limited the ability to draw clear conclusions and assess sustained impact.

The findings of this evaluation highlight the impact and limitations of the St Giles Teachable Moments intervention in A&E, which provides crisis support to young people affected by violence, exploitation, and gang-related harm. The intervention successfully engaged at-risk individuals, particularly boys and

young men, who were identified through clinical coding and safeguarding referrals. However, despite the programme's structured mentoring approach and multi-agency collaboration efforts, several challenges persist that limit its overall effectiveness. One of the key challenges identified in the report is data quality and completeness, with missing values and inconsistent reporting formats making it difficult to conduct a comprehensive evaluation of the intervention's long-term outcomes. Improved data collection and standardisation are necessary to better assess participant progress and intervention effectiveness. Additionally, while the intervention provides immediate support to those presenting at A&E, its ability to measure long-term impact is limited due to short-term engagement and a lack of structured follow-up assessments. Implementing tracking mechanisms beyond the initial crisis support would help determine whether the intervention leads to sustained behavioural change and risk reduction. Additionally, underrepresentation of certain groups, such as girls and young women, ethnic minorities, and individuals with complex needs, suggests that targeted outreach strategies are required to make the intervention more inclusive. The intervention's impact on reducing A&E reattendance was moderate, with some participants demonstrating reduced engagement in violence and increased self-confidence. However, limited progress in areas such as education, employment, and relationship-building suggests that additional support mechanisms—such as vocational training, structured mental health support, and mentorship programmes—could enhance participant outcomes.

The St Giles A&E Teachable Moments intervention plays a critical role in providing immediate crisis intervention and safeguarding support for children and young people experiencing violence and exploitation. The evaluation findings demonstrate success in engaging high-risk individuals and offering tailored mentoring, but also highlight areas requiring improvement, including data management, multi-agency collaboration, and long-term participant tracking. To enhance the effectiveness and sustainability of the intervention, key recommendations include standardising data collection processes, introducing structured follow-up assessments, and developing targeted outreach strategies for underrepresented groups. Additionally, increasing engagement with education, training, and employment services will ensure that participants receive the necessary support to transition into stable and positive life pathways. By implementing these strategic improvements, the St Giles Teachable Moments intervention can continue to build on its successes, delivering meaningful and long-lasting change for young people affected by violence, exploitation, and social vulnerability.

6.0 Recommendations

The recommendations outlined in this report are based on key challenges identified in the St Giles Teachable Moments TM intervention in A&E data. This programme provides trauma-informed crisis support and mentoring for children and young people affected by violence, exploitation, and gang involvement. While the intervention offers immediate safeguarding, certain challenges persist, including data quality, programme sustainability, and targeted engagement. The key areas for improvement are as follows:

1. Data Quality Issues

The evaluation highlighted inconsistencies in data collection, including incomplete demographic information and missing values, which limit the ability to assess outcomes comprehensively. To improve data quality, St Giles A & E should implement standardised data collection templates, provide staff with additional training on data entry and reporting, and strengthen monitoring mechanisms to ensure accuracy and consistency.

2. Measuring Long-Term Impact
St Giles A & E interventions often operate on a short-term basis, with limited follow-up assessments to track participant progress beyond initial engagement. Introducing long-term tracking mechanisms and securing multi-year funding would enable a more comprehensive evaluation of intervention outcomes, ensuring sustained impact.

3. Multi-Response Data Treatment
The inclusion of multi-response variables within the intervention dataset presents challenges in data interpretation and outcome analysis. Refining response formats and adopting more structured analytical methods will ensure that valuable insights into participant needs and intervention effectiveness are not lost. Improved data integration strategies will allow the programme to identify patterns in risk factors, service engagement, and long-term outcomes, ultimately informing more targeted and evidence-based decision-making.

7.0 References

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8.0 Appendix

Theory of Change