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Merseyside Violence Reduction Partnership Whole System Evaluation Report: 2025-26

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MERSEYSIDE VIOLENCE REDUCTION PARTNERSHIP WHOLE SYSTEM EVALUATION REPORT: 2025-26

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About this report

Merseyside is one of several areas allocated funding since 2019 by the UK government to establish a Violence Reduction Unit. To inform the continued development of the Merseyside Violence Reduction Partnership (MVRP) since November 2019, Liverpool John Moores University (LJMU), have been commissioned to evaluate the MVRP as a whole (Quigg et al., 2020, 2021, 2022, 2023), and selected work programmes. In addition, since 2022/23, LJMU have been commissioned to implement additional research to fill gaps in local knowledge. This report forms one of a suite of outputs from the 2025/26 research and evaluation work programme and specifically presents a whole system evaluation of the MVRP. Additional reports for 2025/26 explore:

- Young Futures Prevention Panels (Harris et al., 2026).
- Operation Inclusion (Wilson et al., 2026).
- Custody Navigators (Hearne et al., 2026).
- Be the Change (Smith et al., 2026).
- Neurodiversity Toolkit (McCoy et al., 2026).
- Fire Champions (Smith et al., 2026).
- Children and young people's survey findings (Butler et al., 2026; Quigg et al., 2026).

Outputs are available on the MVRP website: www.merseysidevrp.com or via the author.

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Executive Summary

Merseyside is one of several areas allocated funding by the Home Office since 2019 to establish a multi-agency violence reduction unit (VRU). Merseyside Violence Reduction Partnership (MVRP) aims to take a whole system public health approach to prevention that complements existing multi-agency partnerships and brings together partners to develop a coordinated approach to tackle the root causes of violence. Since 2019, the MVRP has commissioned Liverpool John Moores University and its partners to evaluate the MVRP as a whole and selected work programmes.

Aim: This report is the sixth whole system evaluation of MVRP and specifically aims to explore: how the public health approach to violence prevention is being delivered by MVRP, and how this approach can be sustained across Merseyside. The primary objectives were:

- To assess the progress that the MVRP has made in implementing different components of a public health approach to violence prevention across the region.
- To review the awareness and implementation needs of wider partners across Merseyside in sustaining that approach.
- To identify key learning for the development of a toolkit which can be used by Merseyside partners to support implementation of the public health approach.

Methods: The methodological framework was informed by the whole system approach to public health evaluation (Egan et al., 2019a, 2019b), combining qualitative interviews with partners working in a range of public sector and VCSFE organisations with a role in violence prevention across Merseyside including the MVRP Steering Group (n=28) and a focus group with members of the MVRP team (n=11). The MVRP theory of change, which was developed and refined in previous whole system evaluations (Quigg et al., 2023) was used to guide study design and analysis.

The MVRP theory of change

The MVRP theory of change was developed, tested and refined across the first five years of whole system evaluation (figure 2.1). The theory of change has five core programme theories focusing on: 1) a multidisciplinary team of 'opinion leaders' seconded from partner organisations; 2) strong and committed senior leadership; 3) evidence-based decision making to inform commissioning and implementation; 4) a whole family, life course approach to violence prevention including intervention selection, design and delivery; and 5) working with communities as partners. The qualitative findings from the evaluation indicate that MVRP is generally maintaining good fidelity to this theory of change.

MVRP as a public health approach to violence prevention

Overall, partners were confident that MVRP was delivering a public health approach to violence prevention with participants particularly assured that the interventions implemented were across the primary, secondary and tertiary levels of prevention and addressed risk and protective factors across the life course. Participants identified three key strengths of the MVRP public health approach: 1) shifting organisational culture towards taking a public health approach to violence prevention; 2) promoting multi-agency partnership working; and 3) embedding evaluation to build the evidence base on what works to prevent violence in Merseyside. In line with the theory of change participants identified that supportive leadership at different organisational levels and the presence of passionate 'opinion leaders' with strong networks within the MVRP team were key to achieving the public health approach. However, participants identified that routine consultation and engagement of children and young people, and the wider community was

still an underdeveloped area of the theory of change. Participants also felt further progress was needed on systematically scaling up interventions that had been proven to work across the whole Merseyside region. These priorities are reflected in the recommendations below.

Embedding the public health approach to violence across Merseyside

Findings from partners indicate some promising facilitators of the public health approach across the wider Merseyside system. These include a political will to share violence-related intelligence across partners, good awareness of the wider risk and protective factors, a desire to adhere to the three-tiered model of primary, secondary and tertiary level prevention activity in youth-facing organisations, and value universally placed on routine evaluation to establish evidence on effective interventions. However, the findings also identified several barriers to sustaining the public health approach including a lack of analytical capacity within partner organisations, too great a focus on risk prevention compared with strengths based approaches, lower awareness among organisations focused on tertiary prevention of their role within the whole system public health approach, and a lack of resources and community assets to scale up preventative interventions in reactive frontline services with competing priorities. Actions identified by participants are summarised in the recommendations below and their insights will be used to inform the development of a toolkit for use by partners across Merseyside.

Recommendations to embed the public health approach across the wider Merseyside system

Surveillance

- MVRP should identify a representative to be responsible for coordinating quarterly data lead meetings to feedback emerging data trends from the MVRP data hub to local partners. This will allow this data to promptly inform programme planning within partner organisations.

Develop and evaluate interventions

- MVRP should identify representatives from the team to be responsible for consistently communicating the findings of MVRP funded evaluations, recommissioning decisions and the national evidence on violence prevention including from other VRUs to all partners who are commissioning and delivering violence related interventions (including those not funded by the MVRP), to ensure they can implement what works. This could be done through a consistent agenda item at partnership meetings, routine circulation to partners via email, enhancing the evidence repository on the MVRP website and through continued Merseyside-wide conferences and events.
- The MVRP team and steering group should support partners in establishing evidence-based guidelines across the five local authorities to ensure collective agreement on effective, unevaluated, and potentially harmful interventions. This should include developing shared positions in areas where partners expressed uncertainty, such as the benefits or risks of delivery by individuals with lived experience, the compatibility of 'scare tactic' interventions with trauma-informed practice, and the effectiveness of universal knife-crime education versus its potential to heighten fear and risk perception.
- The MVRP and its partners should consider commissioning or developing internal capacity to conduct cost-benefit analyses of routine evaluation, ensuring that partners have the financial evidence necessary to inform implementation decisions.

Implementation

- MVRP and partners should consider structures to facilitate greater pooling of resources and co-commissioning, for example joint funding across local authorities to prevent duplication across borders and increase economies of scale.
- Partner organisations should look for innovative funding solutions—such as forming new multi-agency partnerships with VCSFE organisations—and consider how the MVRP's effective interventions can be adopted and scaled more systematically across the Merseyside region.
- The MVRP director should sustain existing and continue to identify new relationships with engaged leaders within all partner organisations who are able to advocate within their organisational hierarchy for the public health approach, the implementation of evidence-based interventions, and a focus on early intervention. This can be supported through regular partnership meetings and communications.

Community working

- MVRP should make greater use of VCSFE organisations and community champions to capture youth and community voice in violence prevention messages and strategies by meeting the community where they already are.
- MVRP team should increase the visibility of the work undertaken by the MVRP using these community channels to help build community trust.
- Partners' planning and delivering interventions must be realistic and honest with communities on what could be delivered, with recognition that overpromising could damage trust.
- Senior leaders in partner organisations should advocate for investment in youth work provision to give young people a safe place within their communities and a safety net to return to when they are at risk.

Multi-agency partnerships

- Partnership meetings, whether strategic or operational, should be guided by clear aims and underpinned by regular reporting, review membership regularly, and have suitable Memorandums of Understanding (MoUs) or data-sharing agreements to improve effectiveness.
- System-level change to deliver the 'big wins' of the public health approach relies on senior leaders committing to coherent, region-wide policy, and common approaches. The MVRP and steering group should draw on their networks and strategic leverage to shape and promote these policies.
- Members of the MVRP team can strengthen active partnership working by clearly communicating the MVRP vision to all partners (working in primary, secondary, and tertiary prevention) and by actively widening engagement beyond traditional public-sector agencies to draw on the strengths of VCSFE groups, community members, and relevant commercial and industry partners in Merseyside.

Contents

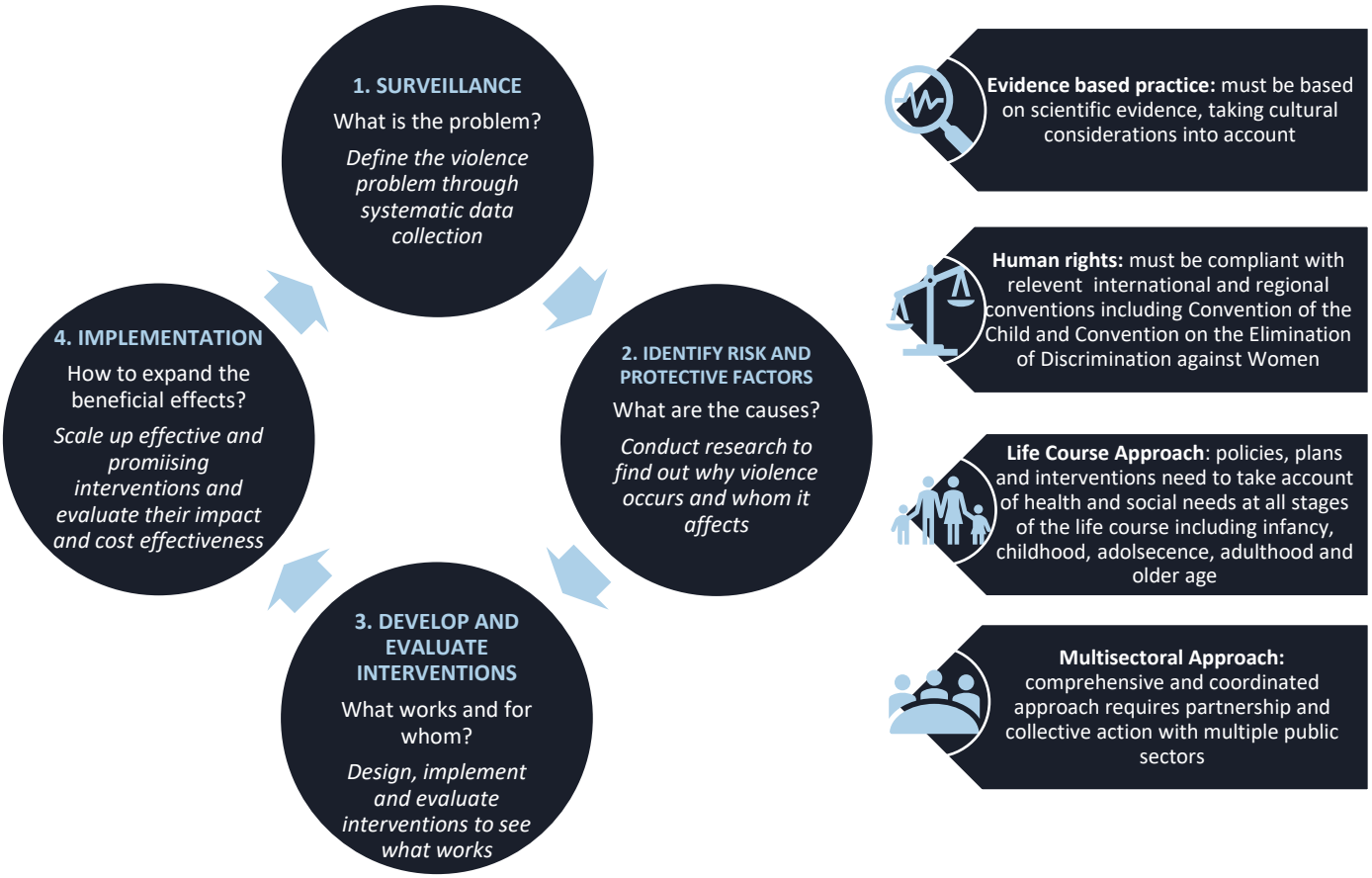
1. Introduction

1.1 Background

Interpersonal violence is a global public health issue, with severe consequences for individuals' health and social prospects across the life course. Violence affects families, communities, and wider society, placing significant burdens on public services including health, criminal justice, social services, and other sectors (WHO, 2014). Internationally and across the UK, there is growing recognition of the advantages of adopting a public health approach to violence prevention which aims to promote population health and wellbeing by addressing the underlying risk factors that increase the likelihood of violence, and promoting protective factors across individual, relationship, community, and societal levels (Krug et al., 2002; Snowdon et al., 2024).

The WHO framework outlines four steps of the public health approach to violence prevention (WHO, 2022). As detailed in figure 1.1, these steps are: 1) surveillance to define the problem through systematic data collection; 2) identify the risk and protective factors to find out why violence occurs, whom it effects and what protects people from harm; 3) develop and evaluate interventions to see what works for whom; and 4) implementation through the scaling up of effective and promising interventions to evaluate their impact and cost effectiveness. Alongside the four-step framework, WHO outline overarching principles of violence prevention approaches: they must be evidence-based, compliant with relevant human rights conventions, and take both a life course and multi-sectoral approach.

Figure 1.1: The Public Health Approach to Violence Prevention (adapted from WHO, 2022)



In 2019, the UK Home Secretary allocated funding to Police and Crime Commissioners in 18 areas to set up or build upon existing multi-agency Violence Reduction Units (VRUs). Merseyside was one of the areas allocated funding and established the Merseyside Violence Reduction Partnership (MVRP). The MVRP aims to take a whole system public health approach to violence prevention that fits within and complements existing multi-agency partnerships. This whole system approach, advocated by the Home Office (2018), involves a programme of activity to bring together relevant partner organisations to develop a coordinated approach to tackle the root causes of violence (PHE, 2019). VRUs were introduced to meet the aims of The Serious Violence Strategy (Home Office, 2018) which advocates using a place-based approach to tackle the root causes of violence, focusing on the strengths and needs of local communities. In 2023, this approach was further mandated in the Serious Violence Duty (Home Office, 2022) which requires public sector partners (including police, local authorities, criminal justice, and health services) to work together collaboratively to reduce violence through local area needs assessment, local area response strategies, and improved data sharing to inform targeted violence prevention interventions.

Since 2019/20, the Home Office has continued to fund VRUs, accompanied by a national evaluation providing evidence on overall processes of programme implementation (Craston et al., 2020), the feasibility of measuring outcomes nationally (MacLeod et al., 2020), and more recently, evidence on outcomes and impacts (Home Office, 2025). Since their commencement, many VRUs have embedded programme evaluation into their local VRU work programmes, developing local programme/intervention logic models and theories of change, and implementing local evaluation of the whole system public health approach to violence prevention (e.g. Wales[1], Timpson et al., 2021) and/or evaluation of place-based approaches and interventions (e.g. West Midlands[2]). In Merseyside, the MVRP have commissioned a range of research and evaluation projects to inform the development and implementation of a public health approach to violence prevention and understand the development and impact of violence prevention interventions. Since November 2019, Liverpool John Moores University (LJMU), have been commissioned to evaluate the MVRP as a whole (Quigg et al., 2020, 2021, 2022, 2023) and selected work programmes, and the implementation of bespoke research projects to fill gaps in knowledge.

1.2 Evaluation objectives and methods (2025/26)

This report aims to explore how the public health approach to violence prevention is being delivered by MVRP and how this approached can be sustained across Merseyside. The primary objectives were:

- To assess the progress that the MVRP has made in implementing different components of a public health approach to violence prevention across the region.
- To review the awareness and implementation needs of wider partners across Merseyside in sustaining that approach.
- To identify key learning for the development of a toolkit which can be used by Merseyside partners to support implementation of the public health approach.

The methodological framework was informed by the whole system approach to public health evaluation, recommended by Egan et al (2019a, 2019b). This approach is deemed most appropriate where there is more than one primary goal being measured and a theory of change is being explored. The MVRP theory of change, which was developed and refined in previous whole system evaluations (Quigg et al., 2023) was used to guide study design and analysis.

[1] https://www.violencepreventionwales.co.uk/research-evidence/evaluation

[2] https://westmidlands-vru.org/evidence-evaluation/evaluation/

Table 1. Whole System Evaluation Methods

Example of Whole System Evaluation Methods	MVRP 2025-26 Evaluation Data Collection/Evidence Used
Qualitative research with a systems lens Sampling participants from different parts of the system, exploring the impact of the MVRP on relationships and change, and understanding how different parts of the system affect one another.	 A focus group (n=11) with practitioners who were working, or had worked, as a member of the operational team of the MVRP between 2025-26.  Interviews with members of the MVRP Steering Group and wider partners working in violence prevention in Merseyside (n=28) representing Merseyside Police, Merseyside Fire and Rescue, Merseyside Probation Service, The Police and Crime Commissioners Office, Public Health, an Integrated Care Board, an NHS acute hospital trust, North West Ambulance Service, Children's Social Care, local authority education departments, three Community and Voluntary Services, three local secondary schools, and Merseyside's five Community Safety Partnerships (CSPs).
Concept mapping Understanding problems, challenges, and solutions through stakeholder engagement. Understanding the broader factors that influence violence prevention activities in Merseyside and present opportunities for change.	 A logic model and theory of change was developed and refined in 2023 to demonstrate the key activities and outcomes of the MVRP. This was used to guide the study design and analysis.

1.3 Structure of the report

To establish how and where the MVRP is progressing towards a whole system public health approach, any gaps in the system, and recommendations to maximise the effectiveness and sustainability of the MVRP, the evaluation findings are presented with reference to the:

- Key principles of a whole system public health approach (see Box 1 and Appendix Table 1).
- World Health Organization (WHO) public health approach to violence prevention (Krug et al., 2002).
- Serious Violence Strategy (Home Office, 2018).
- Additional guidance produced to support VRUs to implement a whole system public health approach to violence prevention (PHE, 2019).

Section 2 presents the MVRP theory of change which has been developed, tested, and refined in previous whole system evaluations.

Section 3 assesses the progress that the MVRP has made in implementing different components of a public health approach to violence prevention across the region, drawing on qualitative insights from stakeholders.

Section 4 reviews the awareness and implementation needs of wider partners across Merseyside in sustaining the public health approach to violence prevention.

Box 1: Implementing a whole system approach to tackling complex public health issues

A range of international policy and guidance recommends the implementation of a whole system approach to tackle complex public health issues and create long-term effective change (Kleinert and Horton, 2015; Mabry and Bures, 2014; Rutter, 2011). Studies have identified the key principles that define a comprehensive whole system public health approach, highlighting the importance of effective operational mechanisms alongside the implementation of effective interventions (Bagnall et al., 2019). A review of studies recommends ten key features that must be addressed when implementing a whole system approach (see Appendix Table 1, Garside et al., 2010; NICE, 2010). A study by Bagnall et al. (2019) explored the published evidence on the application of a whole system approach on public health and related areas (including crime and justice); they found that programmes that addressed each feature were more likely to be successful than those that did not. Issues such as supportive leadership, stakeholder engagement, investment in relationships and sustainability planning were all key to success. Community capacity, trust, and ownership were also identified as important (Bagnall et al., 2019).

2. The MVRP Theory of Change

Figure 2.1 presents the MVRP theory of change describing contextual factors, underlying mechanisms, and resulting activities and outcomes. An initial theory of change was developed in the first three years of the evaluation through stakeholder consultation (interviews n=42, workshop) and tested and refined in the fourth year of the evaluation (interviews n=26).

The MVRP theory of change has five programme theories focusing on:

A MULTIDISCIPLINARY TEAM OF 'OPINION LEADERS'

These team members bring a strong network and understanding of their organisation into a culture where their knowledge feels valued. Partners are more likely to affiliate themselves with people they respect, and secondment gives these team members the time and space to think innovatively and collaborate. These mechanisms allow MVRP team members to develop, select, and fund primary, secondary and tertiary violence prevention interventions based on local need.

STRONG AND COMMITTED SENIOR LEADERSHIP

The MVRP requires a director with sufficient seniority, clear vision and who represents MVRP interests, and a strategic steering group with clearly defined roles and regular communication with the MVRP team. Together these two elements of leadership can create a culture of multi-agency working and drive forward the MVRP agenda (even when partner priorities compete) through shared effort, resources and knowledge. These mechanisms are key to ensuring guidance and policy that embeds the public health approach across the Merseyside system.

EVIDENCE-BASED DECISION MAKING TO INFORM COMMISSIONING AND IMPLEMENTATION

Both MVRP team commitment to evidence-based practice and the availability of funding are key contextual factors which ensure the MVRP team feel confident the work they are doing is working, builds trust and buy-in from partners, builds workforce capacity, and allows testing of interventions to establish what works. This allows MVRP to contribute to the local and national evidence base.

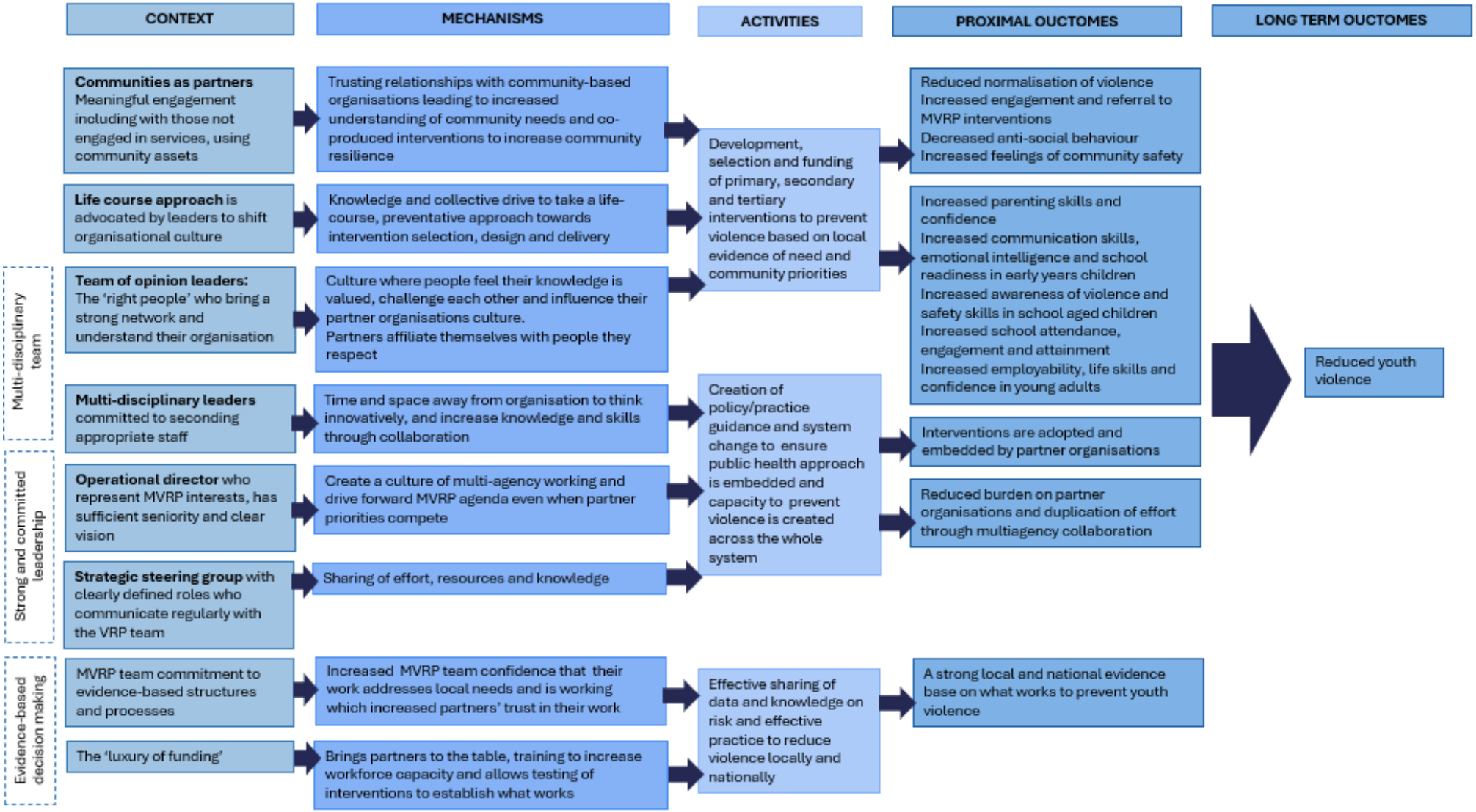
A WHOLE FAMILY, LIFE COURSE APPROACH TO VIOLENCE PREVENTION INCLUDING INTERVENTION SELECTION, DESIGN AND DELIVERY

Advocacy of the life course approach from leaders can shift organisational culture. This creates knowledge and collective drive among partners to take a life course, preventative approach to intervention selection, delivery and design.

WORKING WITH COMMUNITIES AS PARTNERS

Strong community organisations and champions can build trust with young people and communities, including those who are not engaging in services. These trusting relationships can support MVRP in understanding community needs and co-producing interventions that strengthen community assets and increase community resilience.

Figure 2.1: Refined theory of change for Merseyside Violence Reduction Partnership



3. MVRP as a Public Health Approach to Violence Prevention

During the interviews participants were asked to rate their confidence in MVRP as a public health approach to violence on a scale of 1-10. Overall, confidence was relatively high with 96% of respondents reporting a score of seven or above (score range: 6-10). However, views on MVRP's visibility across the Merseyside region were varied. Those with long-term relationships with MVRP (including policing, community safety partnerships, and public health) spoke positively about the primary, secondary, and tertiary interventions implemented across the life course, although many acknowledged that the ultimate outcome of a public health approach was system-level change which would take longer than the current lifespan of MVRP.[3] Some participants described increased engagement with MVRP over the past 12 months including those from children's social care and Integrated Care Boards. In contrast, other participants who had been engaged with MVRP from the outset (such as probation, where MVRP are looking to reestablish a representation on the MVRP team) described reduced clarity around MVRP's vision and felt increasingly on the periphery. Finally, some participants working within certain sectors of the NHS had little-to-no awareness of MVRP including some acute hospital trusts and the North West Ambulance Service. In general, lower awareness and engagement tended to align with areas where there was no current representation on the MVRP team. This aligns with the MVRP programme theory which identifies how having a team of opinion leaders with strong networks within their organisations encourage affiliation to their public health approach.

Participants identified three key strengths of the MVRP which they felt had contributed to the implementation of appropriate primary, secondary, and tertiary-level violence prevention interventions. These were: shifting organisational culture through advocacy of the public health approach, promoting partnership working, and commitment to evidence-based evaluation.

Shifting organisational culture

Overall, participants agreed that MVRP had made progress embedding the public health approach to violence across partner organisations. The two key areas of success described by participants were increased understanding of the theory behind the public health approach, and *"shifting the culture"* (P19) towards more risk and protective factor-focused ways of working. This included trauma-informed and responsive approaches, more neurodivergence informed ways of working, and the design and implementation of preventative, whole life course focused interventions. For organisations who were already on a journey towards more preventative ways of working (such as Merseyside Police and Merseyside Fire and Rescue), the MVRP's promotion of the public health approach had provided them with confirmation that they were taking the right approach. Participants from these organisations tended to have greater confidence that the public health approach to violence could be sustained beyond the life of MVRP.

[3] At the time of interviews, VRUs were waiting for confirmation from UK Government about if, and if so how VRU's would continue across the country. Since this time, UK Government have confirmed that VRU's should continue and will be funded (for an additional 3 years).

> *"… that message about, 'this is a public health approach … this is long-term', that has been there from very much from day one and is reinforced [at] every opportunity. The projects and the interventions that the VRP have been involved in … run very much in that public health scheme and design … working with the VRP over the last five to six years, it's confirmed that my thinking was correct. It's brought that back to the front of my mind and reminds me that, yes, this this is the right approach to take." (P18)*

In contrast, participants in organisations who were currently less focused on prevention tended to have lower confidence that the public health approach could be sustained without MVRP's support. These participants felt that while there was greater understanding of the theory behind the approach, there were not necessarily the tools and resources available outside of MVRP to continue into the long term.

> *"But changing a culture [… in] a century old organisation which has got, I don't know, hundreds of thousands of people working for it, is a job in itself ... if I wasn't doing this role, I don't think it would exist … that … culture in healthcare as to the public health approach to violence, I don't think it would [exist]. It would go back to where we were ten years ago." (FG10)*

In line with the MVRP theory of change, leadership was identified as an important mechanism for the sustainment of the public health approach. Participants were clear that the Home Office had ultimate responsibility for measuring the performance of the MVRP. However, MVRP team members felt that scrutiny of their work by the Home Office had varied considerably during the lifetime of the MVRP and generally felt their work was less constrained to rigid performance metrics compared to their home organisations. Local accountability from Merseyside leadership was therefore seen as vital in shifting culture. As in the MVRP theory of change, leaders were identified at multiple levels including: a) the MVRP steering group who scrutinised *"decision making and financial decisions"* (FG4); b) the MVRP director who was described as *"progressive in their thinking and their response to serious violence"*; and c) leaders within partner organisations who acted *"as advocates … within the hierarchy … that really understand public health approaches … and how collegiately we work together to address that"* (FG1).

> *"… it starts with one person, doesn't it? ... a vision that this can't carry on and things aren't getting better. So, we need to change … I started to change things on my own, but I couldn't ever have had the sea change that's happened without the VRP." (P19)*

Promoting partnership working

The development of strong multi-agency partnerships was frequently described by participants as a strength of MVRP. Participants felt MVRP played a key role in coordinating a pan-Merseyside approach to violence prevention, which helped partners to increase their understanding of their fit with other services and within the life course model. Well-engaged partners described the MVRP as well-connected and achieving good partner buy-in. Examples were also given of the MVRP creating new partnerships with agencies who previously had not been represented in multi-agency meetings. As illustrated in the quotes below, this was particularly the case for VCSFE agencies such as Ariel Trust and Merseyside Youth Association who felt MVRP had increased the reach of their school-based programmes and allowed them and the young people they supported to be actively consulted in Merseyside strategy and policy. A smaller number of participants highlighted the importance of

identifying and building industry partnerships beyond standard agency partners for example in night life and town/city centre spaces.

> *"… they did have a transformational impact upon Ariel Trust … we've adopted the public health approach to drive and structure our work … we now have more than a third of primary schools across Merseyside signed up to deliver it … and it's growing. That doesn't happen without the support of the VRU … that is a very dynamic partnership with schools across the region … and that's something that the VRU have created." (P20)*

> *"This year particularly, I've seen a lot more work being done around our involvement as a youth organisation in the violence prevention world … we've been trying to connect more with VRP services … that are also doing similar violence prevention work … how can we utilise youth voice that you've already got … So, for example, we're now currently working with the Police and Crime Commissioner to host some youth voice consultations around violence against women and girls … we've now joined the Antisocial Behaviour Partnership Board so that we can inform this antisocial behaviour action plan with youth voice … the public health approach this year for me has really stood out." (P22)*

However, some participants did not feel fully embedded within the partnership describing *"a lack of clarity about what [MVRP] want"* which prevented them from identifying "*how we'll connect … and work out what overcoming those barriers looks like"* (P3). Others described inequality of contribution: "*we feed more to the VRP than the VRP feeds to us … we seem to feed in a lot. We don't seem to get much back"* (P5). Some partners felt the MVRP continued to be Liverpool-centric in terms of the provider organisations and programmes selected and evaluated. MVRP team members also acknowledged their desire to continue to strengthen and improve their partnerships, with a team member stating, *"we've got our long-standing programmes, that are really well thought of, there's a feeling that partners … need [MVRP] to be slightly more reactional in what we're doing, in terms of what they need*" (FG3). As in previous evaluations, MVRP team members also recognised that youth and community voice were sometimes lacking in their partnership discussions and recognised this as an area they wished to improve.

In line with the MVRP theory of change, MVRP team members felt that seconding staff with strong networks and personal commitment to violence prevention (termed 'opinion leaders' in the theory of change) was important for sustaining partnerships. As one team member described: *"everyone here is such a positive, proactive person in their own [professional] world … if they can't do, they know someone who can do, or they can put you in contact with someone who can do"* (FG9). Participants also recognised that the context of Merseyside as a region had impact upon partnership working. Participants felt Merseyside had a strong historical culture of partnership working. Some participants highlighted that the region had also experienced several significant incidents of violence over the past five years which had shaped how partnerships evolved by strengthening working relationships but also shifting focus and reducing capacity for some partners as they worked on direct responses to these incidents.

Commitment to evidence-based evaluation

Participants described MVRP as committed to the evidence-based nature of the public health approach to violence prevention. In line with the theory of change, they acknowledged that routine evaluation of interventions had been put in place from the outset of the MVRP, and there was

universal appreciation from participants that this approach was increasing their understanding of what works to prevent violence. The MVRP team described *"a shift in the past five years around the ways our partners are thinking about interventions they commission … a lot more thought that goes into the evidence"* (FG4) which was reflected in their discussions with partners, governance structures, and bids received. Participating providers also discussed an increased focus on intervention fidelity and using the outcomes of their evaluations to make evidence-based adaption. Several providers also described how they had been asked to contribute their learning to the national evidence base, contributing to national toolkits or sharing best practice with partners in other VRU regions.

> *"… one of the key things that I think the VRP did at the very outset, was … having that evaluation from LJMU … prevalent to every stage … to understand what works and what doesn't work. So, for me, in five years' time, that approach will bear fruit … the evidence will be there as to what works and what doesn't work … that's the absolute overall key thing that the VRP did from day one … that will have impact, and lasting impact." (P18)*

Participants highlighted, however, that communication could be improved to ensure learning from evaluations reached all relevant partners. For example, some participants felt that the supporting evidence which led to the decommissioning of a hospital-based intervention had not been shared with relevant NHS partners. Participants felt that now the MVRP was well-established, there should be greater focus on *"deliberative and intentional"* (P8) scaling up of interventions with a strong evidence base across Merseyside, as described in the fourth stage of the public health approach to violence. However, participants acknowledged this came with challenges in the current political and financial climate, where there was uncertainty about the long-term sustainment of VRUs nationally. Some participants also noted that external evaluation tended to be commissioned for larger, Merseyside-wide interventions, and would like consideration of how the evidence base from smaller, local authority level interventions funded by the MVRP could be shared and utilised more readily.

4. Embedding the Public Health Approach to Violence Across Merseyside

Surveillance

The public health approach to violence requires whole system partners to define the problem through systematic data collection on the magnitude, scope, characteristics, and consequences of violence. Previous annual whole system evaluations of MVRP highlighted good surveillance practices through the development of a VRP Problem Profile and MVRP data hub (which collates data from local A&Es, North West Ambulance Service, and Merseyside Police). However, there remained concerns in previous evaluations that there was insufficient linking with intelligence gathered by wider partners, and that the data collected was not being systematically used across the wider Merseyside system to inform violence prevention efforts.

Participants in the 2025/26 evaluation felt there was willingness across the whole Merseyside system to collaboratively share intelligence to respond to violence. At a national level, participants noted that data-driven practice was now routine for many public sector organisations (with examples including benchmarking, dashboard development, trend monitoring, and hotspot identification) and that national policy directives in the past decade had increasingly focused on multi-agency sharing of this data. Locally, several participants agreed that relationships built by MVRP had made a cultural difference, with growing willingness among partners to proactively identify data-sharing solutions to facilitate violence prevention within Merseyside's communities.

> *"... across Merseyside … there's a real energy across the partnership … to do what's best and to find ways of working together. We're all on the same page … all got the same drivers … People don't hide behind GDPR for example, if they can share stuff, they do." (P18)*

The most significant perceived barrier to comprehensive violence surveillance was a lack of analyst capacity. Participants from MVRP, police, community safety partnerships, NHS and the office of the PCC all cited analyst vacancies. Without an analytical function to present trend data and identify the scale of problem, participants felt their services were more likely to respond reactively or interpret data based on political priorities rather than planning collective multi-agency action. Participants felt a lack of analyst capacity had the greatest impact on the development of early and strengths-based interventions. For example, participants acknowledged that while there were potentially large quantities of data on adverse childhood experiences (ACEs) held by the NHS, or young people's peer networks held by education and social care sectors, partners lacked the analytical capacity to monitor and act upon that data at any scale. Some participants also expressed concerns that local authorities often relied on national datasets which could be already dated by the time they were made available.

> *"You've got the data hub … I don't think we make the best use of that … it's left to each individual Data Lead in the local authorities to make use of it … there needs to be a [MVRP lead] data subgroup, bringing all those data people together … to analyse data and trends … I can design services and interventions, once I know what the data is telling me, so I can be data led, but we need other people to be interrogating that data, and then analysing that data, and feeding that to the likes of me, so that we can begin to decide how we focus our limited resources." (P6).*

Surveillance actions recommended by participants:

- Participants recommended that MVRP coordinate a quarterly data leads meeting which allowed them to feedback emerging data trends from the data hub (and other sources) to local partners. This would ensure the data was promptly communicated to partners to allow them to plan programmes.

Identify risk and protective factors

The public health approach to violence advocates using research to establish the factors which increase or decrease the risk of violence to establish why violence occurs and which of these factors could be moderated through intervention. The MVRP theory of change identifies: 1) partner-wide awareness that identifying risk and protective factors across the life course is important; and 2) training practitioners to be trauma informed as key mechanisms of change.

In this year's evaluation, participants across the whole system identified risk and protective factors which clearly aligned with MVRP's existing priorities. Protective factors identified were early years, whole family intervention, trauma-informed practice, and keeping young people positively engaged in education. The risk factors most frequently discussed were adverse childhood experiences (ACEs), socio-economic deprivation, having a Special Educational Need (SEN), being neurodiverse, missing episodes, and engagement in antisocial behaviour. Several participants felt MVRP had facilitated an increased awareness of risk and protective factors across the life course within their organisations, with ACEs, trauma, and being neurodivergent most frequently mentioned.

> *"… take, for example, the county lines task force…they really […have] become trauma-informed … we actually have a [CGL] drug worker who goes out on patrol with the task force … There is this mindset shift of … they're somebody who has had a traumatic life … thinking about treatment, recovery, as opposed to seeing them as a criminal, and we should be arresting them. And that's been one of the biggest shifts in mindset I've seen from a particular team almost ever within policing, … they've done that themselves … a team that are driven by how many arrests." (P12)*

As in previous whole system evaluations, participants remained concerned that without continued financial support and coordination from the MVRP, their capacity to implement preventative interventions would become limited. Participants in responsive frontline organisations were focused on reacting to the most pressing priority and felt they did not have time or capacity to plan preventative responses to wider underlying risk factors. Some participants also expressed concerns that most preventative approaches focused specifically on risk factors and those who had committed acts of violence, with comparatively less attention given to protective factors and the needs of victims and communities impacted by violence. Several participants discussed the *Be The Change* Programme in Knowsley as an example of deliberately shifting their intervention focus away from educating young people about the consequences of risk (such as knife crime) to look at positive, strengths-based and protective opportunities for young people within their local communities.

> *"… what we haven't done is invested enough to respond because we're all firefighting … because we're all resource-led … capacity is an issue for everybody…We haven't slowed down enough to capture the data to then be able to present it and say this is the response … I don't think anyone sort of lifted their head up enough to be able to do that."* (P10)

Identifying risk and protective factor actions recommended by participants:

- Workforce-level toolkits and training to increase awareness and change practice. Examples of good existing practice included the MVRP Neurodiversity Toolkit and trauma informed training programme.
- Partnership meetings which brought relevant partners together to consider risk and protective factors at different levels of the socio-ecological model. Existing examples included the Young Futures Prevention Panel pilots (individual level), Community Safety Partnerships and City Safe Groups (community level) and the Violence Against Women and Girls Strategy Group (societal level).

Develop and evaluate interventions

The third step of the public health approach to violence is to use the information gathered to design and evaluate interventions and understand what works for whom. Prevention activity is often mapped to three levels: 1) primary prevention – which aims to prevent harm before it occurs by focusing on the root causes and taking an upstream and often whole population approach; 2) secondary prevention – is targeted towards those at-risk of harm, aiming to reduce risks of harm, and prevent further exposure; and 3) tertiary prevention – targets those who have been involved in violence or exposed to harm and aims to prevent reoccurrence, escalation and further harm. Increasing partners understanding, development and monitoring of evidence-based interventions are key mechanisms in the MVRP theory of change to achieving robust, evidence-based practice and decision-making.

Design

Some participants demonstrated strong understanding of the three-tiered approach to prevention, particularly those who were working directly with young people and referring them into appropriate support. For example, all three school-based participants described a clear model of provision which combined violence education programmes for students at the primary level (for example universal-targeted approaches such as Mentors in Violence Prevention, Ariel Trust, or Fire Champions) with secondary level targeted prevention for young people with higher risk factors (for example school based sessions delivered by Anthony Walker Foundation, and referrals to YPAS, LFC Foundation, and local boxing programmes*)* and tertiary prevention for young people where there were safeguarding concerns (usually through statutory referrals to programmes such as SAFE or to school police liaison officers). In contrast, participants who were working with adults in the tertiary prevention sphere (for example Probation and NWAS) and those who were delivering targeted hotspot work expressed less certainty about how their work fitted into the whole system public health approach in Merseyside.

> *" I really like the model … of course, all the things that make the news headlines … all kind of the physical violence … [are] at the very top of that pyramid. But it's going back to kind of how those beliefs and those attitudes and those behaviours … if we don't correct them at that low level, how they can very easily escalate to become something much more serious, and obviously in any school where you've got large amounts of young people together … if we don't kind of address them at the root cause, they can very quickly escalate upwards …we'll often refer to MVP in other areas of school that we do." (P27)*

Generally, participants recognised the value of using evidence-based interventions at both an individual and strategic level, but there was variation in how this was acted upon. Organisations working at the tertiary level (for example probation and police) were often delivering interventions that were mandated nationally and monitored centrally. In contrast, many participants working at the primary and secondary level described drawing on published evidence and national toolkits (e.g. YEF, College of Policing) but they also recognised that implementing these interventions into local contexts may require adaption and further evaluation. Asset mapping was also described as an important activity in intervention design, with participants giving examples of how the asset mapping undertaken for Serious Violence Duty and recent Neurodiversity Toolkit had helped them consider gaps in local provision where intervention may be required. Participants also felt that MVRP could play a more central role in communicating the evidence on best practice to partners from both MVRP funded interventions and the national evidence base. Participants' recommended actions are summarised below.

> *"if that catalogue was shared by the VRP … and not only that, it should be a little bit more directive as in: this is what you can deliver, and if you go off-piste with that, and decide to deliver something that's not trauma informed well then on your head be it." (P19)*

Evaluate

Participants consistently acknowledged the value of evaluating interventions in order to determine what works, for whom, and why. Most statutory organisations described monitoring of outcomes as a standard requirement of their provision which aligned with a growing emphasis on rigour and evidencing outcomes over the past decade. VCSFE sector participants, who were implementing interventions, recognised the importance of evaluation findings to help them adjust and improve their practice, justify continued commissioning, and increase their reach. Participants also acknowledged that evaluations were also valuable in identifying where evidence-based models did not work within the Merseyside context, or where practices were harmful.

> *"… we've noticed a shift in the past five years around the way our partners are thinking around interventions that they commission … the evidence around those interventions … I think we've [the MVRP] been a key player in driving some of that thinking … our governance structures around having that strong evidence base … not using the evidence base as a barrier to not trying new things. I think there is that flexible approach there… I would hope, in the next five years that that line of thinking would continue." (FG4)*

Participants acknowledged the value of process evaluation data alongside outcome monitoring (for example by measuring engagement and capturing the voices of children, young people, and families) to give implementers insight into how and why interventions worked, their acceptability to participants, and understanding of shorter-term positive impacts (for example new knowledge, skills or techniques, and changes in attitudes and behaviours). This was particularly valued for universal and lower tier prevention activities where primary outcomes could be more challenging to measure. Participants identified a number of resource-related barriers to routine evaluation. Although they recognised that robust monitoring systems facilitate more effective evaluation, they questioned the value of significant analytical investment or new system procurement where interventions lacked secure long-term funding. They further noted that follow-up data collection—such as 3-, 6-, and 12-month measurements—is often undertaken by practitioners with substantial caseloads, placing additional demands on their time.

> *"It's about engagement … if you've got high engagement, and you've not got a high drop off, that shows … that interest. It's that feedback from the young people, it's feedback from parents, it's feedback from schools … it's a whole range of different feedback mechanisms that we use to gauge the success of the programmes … we don't just keep recommissioning year on year, because we've always done it. We do ask ourselves, 'Is it time to look at something different?', 'Is this getting a bit tired?"*
> (P18)

Design and evaluation actions suggested by participants:

- Several participants felt the MVRP could play a greater central role in communicating the national evidence and best practice VRP funded interventions to partners.
- Participants identified several areas where there was uncertainty over the most effective approach such as whether delivery by people with lived experience criminal justice involvement was a positive or negative component, and whether using universal knife crime education was preventative or if it heightened fear and risk perception. Partners expressed a desire to establish agreement on common intervention approaches across local authorities which were based on effective interventions and evidence-based service improvements.
- Evaluations should also include economic evaluation for example a cost-benefit analysis.

Implementation

The final step in the public health approach to violence is implementation; using the evidence generated to scale up effective and promising interventions, programmes, and policies. In line with the theory of change, participants felt that MVRP's commitment to identifying and funding evidence-based practice had created a forum for shared implementation learning. Participants described core mechanisms at an individual, relationship, community, and system level that they felt were key to the implementation of violence prevention interventions.

At the individual and relationship levels, the most frequently discussed mechanisms for youth-based interventions were the practitioner's ability to build a trusting relationship with the young person (with an acknowledgement that youth work services were often more trusted than statutory services like the police and social care), connecting young people with positive peers, and taking a whole family approach to support.

> *"… very much about that trusted relationship role … that'll take time to build, but I think if we get that buy in of interests and hobbies … what we'll do is hopefully improve their social wellbeing immediately … or a peer group that's much more healthy and more positive." (P10)*

At a community level, participants highlighted that positive diversionary activities within communities were an important protective intervention but that significant reductions in youth service funding and provision meant these opportunities were often limited to short-term or one-off activities. Participants also specifically discussed school-based interventions and challenges of implementation including fitting in with term cycles, educational priorities and school staff capacity. Participants noted there was sometimes a disconnect between those planning interventions and the education context they were being delivered in, for example Merseyside Police participants have appointed a school's officer with an education background to try and improve relationships. Effective approaches to engage schools included using youth worker (such as MVP) or frontline practitioner delivered models (such as Fire Champions) to reduce capacity pressures on schools, and co-creation with schools to ensure interventions are informed by their ideas and align with their national curriculum targets (e.g. Ariel Trust).

> *"That prevention element around investing in Youth Services … they've been decimated since austerity. And the impact of that is really like evident these days … constant feedback that we get not only from the community but from children's Social Care colleagues … "there's nothing for kids to do."* (P11)

At a system level, participants suggested that communication was an important mechanism of implementation that was often overlooked. Raising awareness of a new intervention among partners was seen as a vital step of implementation to make sure the widest range of eligible young people, families and community members were appropriately referred or signposted. However, participants felt that there remained some system level barriers to successfully scaling up interventions. The greatest challenge identified was competing priorities and lack of resource in the system, with most partners balancing violence prevention with other priorities. Some participants described positive examples of pooling funding to increase economies of scale (for example all five local authorities had pooled funding from their Crime Reduction Grant to fund street-based interventions by Merseyside Fire and Rescue to reduce deliberate fire setting and serious youth violence, and upscale youth engagement) or to allow greater oversight of interventions (for example MVRP and PCC office had coordinated funding streams). Participants also acknowledged that even interventions with a strong evidence base could not be scaled up without community support and available assets within the community to sustain them. Several recommendations were made in relation to funding and leadership which are described in the box below.

> *"It's just ongoing advocation… utilising the research that's out there and the investment that has been put in to demonstrate impact…We need that senior leadership buy in to advocate round the right tables…that commitment to realign existing resource and say actually we're going to make a really difficult decision here and we're going to stop investing in that and move it to that." (P11)*

Implementation actions suggested by participants:

- Some participants also expressed a desire for greater pooling of resources and co-commissioning across local authorities to prevent duplication across borders and increase economies of scale.
- Participants felt future focus needed to be on more innovative ways of securing funding for example through partnerships with VCSFE organisations, new partnerships between organisations.
- Partners also felt the VRP should prioritise cost benefit analysis to enable their decision making to be more financially orientated.
- Leadership was seen as playing an important role in this by advocating for demonstrable impact and making use of the evidence when making resource and investment decisions.

Community working

Alongside taking a public health approach, the serious violence strategy recognises that partners must put communities and local partnerships at the heart of what they do. They recommend this is achieved by helping communities to build resilience, responding and reducing the opportunities for violence and related crime to take place, and raising awareness of key issues for communities and how best to respond. Communities as partners is a core element of the MVRP theory of change. During the previous whole system evaluation (2023/24) MVRP felt they had increased their understanding of community priorities but were still working towards having a trusting responsive relationship with communities and implementing place-based approaches.

For participants from statutory organisations, the focus on community working in the Serious Violence Duty aligned with the wider political priorities within their organisations. Participants described how community consultation and participation work was becoming increasing integrated into their systems and policies. When applied to approaches to tackle violence, most participants emphasised using consultation to understand local communities' priorities rather than simply assuming which interventions communities would like to engage with. Examples of regular consultation included through participation panels (for example local authority youth panels for children with experience of care and NHS trust patient participation groups) and regular surveys to gain feedback from local communities (for example police, PCC, ICB). This was coupled with a shift towards more community orientated terminology and language with participants also consistently citing training on trauma informed approaches and neurodiversity.

> *"It's all well and good for us as professionals thinking we know what we need to deliver but we don't live in those communities … it's absolutely vital to listen to those voices because they live that experience … they know what the issues are … we then need to shape our services around it … we're delivering what people are asking for rather than what we believe that community or that child needs." (P10)*

At a system level, participants described how this was accompanied by a shift back towards community-level structures including neighbourhood models within local authorities and ICBs, contextual safeguarding approaches within children's social care, and locality and hotspot policing approaches. Participants acknowledge that VCSFE organisations (including youth services, charities,

sports, and arts programmes) were crucial partners in engaging and building resilience with communities due to their trusted reputation, flexible and bespoke ways of working and knowledge of their communities' culture and values. For example, Ariel Trust co-designed their education programmes with local educators and facilitated drama workshops where children, parents and police officers could come together to create solutions. Merseyside Youth Association described how they had facilitated consultation through their youth panels on key strategy documents including Merseyside Police's VAWG strategy and the MVRP Strategy.

> *"… their venue, their attitude, their culture, their value base … they're not just a Monday to Friday 9 till 5 service … they are trusted organisations that are well established and reputationally we know that they can do this work and they have the flexibility to be bespoke." (P10)*

However, participants also highlighted that communities were not homogenous and could exist at almost any grouping or geography. Participants were conscious that sometimes the community voices which were most heard weren't always the voices that were most impacted by intervention. This was due to a range of factors including distrust of authority and potential overemphasis on perpetrator versus victim voices. In line with the MVRP theory of change, participants noted that the ideal level of community participation would be for violence reduction activities to be completely community led. There were some positive examples of this given by participants including the Sefton Think ACEs, Create PACEs group, where activities and training are led by parents who have experienced ACEs, and a recent bid from the Clear Hold Build site in Everton to address serious organised crime in their local community. However, participants acknowledged that this level of community participation took time and required resourcing and nurturing by partners.

> *"… we've always found that if you work closely with the young people involved and they feel a sense of ownership, then the likelihood is that they will drive it … a quick example … so for Safer Streets [round] 4, we used some Violence Reduction Partnership [funding] to supplement that … within one of our OCG hotspots … the young people there were saying we just want to shelter outside the community centre … they've asked for it and it's not expensive and we can resource it. So, why wouldn't you? ... on the whole they have managed that shelter … they're not hanging around and causing anti-social behaviour … where there is a potential that they are vulnerable and may be exploited potentially … bring that ownership and that buy in from young people within our communities rather than us going "no, no, no". (P21)*

Community working actions suggested by participants:

- Participants recognised that VCSFE organisations and community champions are important partners who can amplify violence prevention messages by meeting the community where they already are.
- The visibility of work done by MVRP needs to be increased in communities to help build community trust.
- Participants felt it was important to be realistic and honest with communities on what could be delivered, with recognition that overpromising could damage trust.
- Investment in young provision and youth work was views as important to give young people a safe place within their communities and a safety net to return to when they were at risk.

Multi-agency partnership working

The UK Serious Violence Duty recognises that a public health approach to violence cannot be achieved by law enforcement organisations in isolation, rather that it requires a multi-agency approach from partners across different sectors. Four areas of the MVRP theory of change are key to multiagency working: the multi-disciplinary MVRP team, 'opinion leaders' who are well connected with their organisations, a region-wide strategic steering group, and committed senior leadership. Across interviews and focus groups, practitioners who expressed clarity about their role within the wider MVRP model — both as individuals and as representatives of their host organisations — were those who demonstrated the greatest confidence in the benefits of effective, public health-informed multi-agency working.

Generally, participants felt Merseyside had a good history of partnership working, with participants describing a *"straight talking"* and *"emotionally intelligent"* culture (P1), engaged leaders, and a will to work in partnership. Within violence prevention, participants felt the MVRP, PCC Office and Community Safety Partnerships had created strong partnership structures. Some partners felt their inclusion in the MVRP had increased in the past 2 years (since previous whole system evaluation). This included increased feelings of recognition by the VCSFE sector and greater inclusion of partners in children's social care. However, participants also identified some areas where they felt partnership was less strong including health and education. Participants acknowledged that the scale, complexity and structure of these disciplines made it challenging to identify individuals who could accurately represent all the relevant issues and partners. Participants also felt that public health departments were underrepresented in the current structure despite having a key role in collating data, communicating insights from the evidence base and guiding existing partnerships.

> *"I don't think it's always on us [public health] to respond, but often we fill gaps where people … haven't either spotted that gap or don't have the headspace or the capacity to do it. So really our role should be around the data, the insight, the evidence base, best practise and … pointing them in the right direction … Sometimes our role goes a little bit further … like making the case, 'Why does this matter?', 'What's the implications of the data?" (P13)*

> *"I think sometimes people see us as representing the NHS, and I'll be totally honest, it's really, really hard to represent the entirety of the NHS … we are a really complex NHS system across Merseyside … we've got Acute Trusts, maternity organisations, primary care networks … to be able to think about all of the opportunities that sit across the NHS is quite complex." (P2)*

At a strategic level, participants discussed the importance of partnership meetings and leadership. Participants discussed how *"getting all the agencies around the table"* (P10) required the strategic benefits of partnership to be communicated in a way which aligned with each partner's priorities and key indicators. Multiple stakeholders emphasised that partnership meetings had to move beyond attendance to having a clear strategic vision with actions that were routinely allocated and monitored. A range of practical actions for partnership meetings were identified which are summarised in the box below. Participants also emphasised that partnership meetings had to select attendees who were at the right level within their organisation and with the time, resources and capacity to deliver what was required of them.

> *"I suppose it's having that space and time to do something with that connection, because it's all good coming along… and saying I go to a meeting, but so what do we do with that?"* (P11)

> *"Right people, right level, time to deliver and resource…clarity of purpose, clear terms of reference, clear goals, actual financing, resourcing, longevity."* (P3)

Participants therefore felt that partnership meetings were required at different levels (strategic, operational, task groups) to achieve different elements of the public health approach. The MVRP theory of change acknowledges the role of 'opinion leaders' who have the right network and understanding to influence their organisation at a practitioner or delivery level. Participants equally identified that individuals who *"want to do the right thing for their communities"* (FG1) and who have strong existing professional relationships were more likely to progress with the required actions. However, some participants expressed concern that the MVRP had become too focused on the operational elements of the public health approach and that the role of strategic partners in guiding and setting priorities (for example the MVRP steering group) was under-utilised. Several participants highlighted that achieving the whole system, multi-agency ambitions of the public health approach were not just about coordinating individual level interventions, but about creating system change. Participants emphasised that this approach would not produce 'quick win' outcomes but was a longer process to produce a small number of 'big win' changes. For example, several participants noted a variety of knife-crime based education programmes being implemented with uncertainty about which approaches were effective or harmful. In contrast, one participant suggested a whole system response would to be to create a clear charter on how knife crime should be addressed and get all schools in the region to sign-up to this.

> *"When you're … taking that public health approach a) you have to recognise it's really complex … you're not going to make progress in six to twelve months … it's long-term system change … b) you're only going to change a couple of things every year … big wins … that will pay off for you in the long term … introducing policies, getting people to sign up to it … If the system accepts it … that's going to achieve more impact, for a bigger number of people, than doing diversionary activities for 200 kids, or whatever." (P2)*

In line with the MVRP theory of change, participants therefore identified that endorsement from senior, strategic leadership who held their organisation to account was vital to achieving a whole system public health approach. Participants described leaders who *"set out their stall early"* (P12) in terms of their expectations, but who also created a tone that let their teams know they could innovate, be supported in their ideas and have their good work recognised. In contrast, regular turnover of senior managers was identified as a barrier which could result in inconsistency of approach and reduced workforce awareness of the public health approach. For example, participants spoke positively about the wide reach and individual level outcomes achieved by the trauma-informed training programme but also acknowledge that *"it doesn't prevent the underlying processing systems … from still not being trauma-informed"* (P2) and that responses should focus on structural interventions such as board level sign up, training of senior executives and organisational self-assessment.

> *"… where you set your stall out … always given the staff the space to think differently … creating that space of innovation … and not being diminished if something doesn't work … when you drive leadership forward like that, teams*

naturally think a bit differently about how they can get better at what they do … good people in those teams who think for themselves." (P12)

Finally, participants expressed concern that if these key mechanisms from the MVRP theory of change were removed (seconded staff, consistent funding, committed leadership) then partners may struggle to maintain the same level of momentum with the public health approach to violence. Participants acknowledged that the Serious Violence Duty could occasionally be used to hold partners to account to some elements of the public health approach as it gave some formal, mandatory governance and reporting mechanisms, but that it often did not consider local context. Even though many partners were highly motivated to reduce violence in Merseyside, participants recognised that resourcing of their services always followed national decision-making. Without sufficient energy for the public health approach or measurement of violence-related objectives in the national system, current approaches were less likely to get sustained as priorities moved on.

> *"It [Serious Violence Duty] makes it a bit more formal … you can use … those levers to your advantage … there's probably pros and cons, if something's too much nationally mandated … then that isn't always massively helpful, because local context is really important … but … then resource often follows national kind of policy and decision making. So, when it's a national priority, with a national policy drive … then usually you get a little bit of resource there as well, which makes it a little bit easier to do stuff … then when resources move away or you get asked to build on your sustainability plans, the reality is the energy in the room does drop, because the system moves with that energy … Partnerships also can take time to build, and energy leaves a system pretty quickly." (P13)*

Multi-agency partnership actions suggested by participants

- Partnership meetings should have clear aims with regular reporting systems and appropriate memorandums of understanding or data sharing agreements to increase effectiveness.
- Partnership meeting membership should be regularly reviewed and refreshed to ensure consistent attendance and maximum effectiveness.
- Participants suggested having meetings at both strategic and sub-group operational level based on the outcomes wanting to be achieved.
- Participants felt partnership at the strategic level through senior leadership is vital to achieving the 'big wins' of a public health approach. System level change requires partners to sign up to region wide policy and common approaches.

5. Conclusion and Recommendations to Achieve Long-term Impact

Seven years after the implementation of VRUs, this report reviews the progress of the MVRP and surrounding system in implementing different components of the public health approach to violence prevention across the region. Overall, partners were confident that the MVRP was delivering a public health approach to violence prevention with participants particularly assured that the interventions implemented were across the primary, secondary and tertiary levels of prevention and addressed risk and protective factors across the life course. Participants identified three key strengths of the MVRP public health approach: 1) shifting organisational culture towards recognising the risk and protective factors associated with violence across the life course; 2) promoting multi-agency partnership working; and 3) embedding evaluation to build the evidence base on what works to prevent violence in Merseyside. Participants identified that supportive leadership at different organisational levels and the presence of passionate 'opinion leaders' with strong networks within the MVRP team were key to achieving the public health approach. These contextual factors align with the existing MVRP theory of change suggesting that MVRP is largely maintaining fidelity and continuing to progress towards the outcomes described. However, participants identified that routine consultation and engagement of young people and the wider community, was still an underdeveloped area of the theory of change. Participants also felt further progress was needed on systematically scaling up interventions that had been proven to work across the whole Merseyside region. These priorities are reflected in the recommendations below.

Secondly, this whole system evaluation aimed to review the awareness and implementation needs of wider Merseyside partners in relation to the public health approach. Gaining wider perspectives from the Merseyside system gives important insight into the sustainability of the public health approach both with and without the support of the MVRP. The findings indicate a political will to share intelligence on violence across the Merseyside system, but this is being hindered by a lack of analytical capacity within partner organisations. Awareness of the risk and protective factors related to violence was strong across all partners, although some partners felt there was too great a focus on risk reduction as opposed to strengths-based approaches. Those in frontline, responsive organisations were also concerned that awareness of risk and protective factors would not necessarily translate into preventative intervention without the ongoing strategic and financial support of the MVRP. Participants in young person-facing organisations demonstrated good knowledge of the three-tiered model of prevention activity, although those working at the tertiary end of prevention were less likely to see their contribution to the wider public health approach. There was universal understanding of the value of evidence-based interventions, with most public sector organisations required by national mandates to monitor outcomes. However, participants noted the challenges of adapting these systems to capture intervention specific outcomes and of measuring the effectiveness of universal, lower tier prevention activities. Finally, participants suggested the most significant barriers to scaling up effective interventions were competing priorities and lack of resources and community assets to sustain them. Actions identified by participants are summarised below and their insights will be used to inform the development of a toolkit for use by partners across Merseyside.

Recommendations to embed the public health approach across the wider Merseyside system

Surveillance

- MVRP should identify a representative to be responsible for coordinating quarterly data lead meetings to feedback emerging data trends from the MVRP data hub to local partners. This will allow this data to promptly inform programme planning within partner organisations.

Develop and evaluate interventions

- MVRP should identify representatives from the team to be responsible for consistently communicating the findings of MVRP funded evaluations, recommissioning decisions and the national evidence on violence prevention including from other VRUs to all partners who are commissioning and delivering violence related interventions (including those not funded by the MVRP) to ensure they can implement what works. This could be done through a consistent agenda item at partnership meetings, routine circulation to partners via email, enhancing the evidence repository on the MVRP website and through continued Merseyside wide conferences and events.
- The MVRP team and steering group should support partners in establishing evidence-based guidelines across the five local authorities to ensure collective agreement on effective, unevaluated, and potentially harmful interventions. This should include developing shared positions in areas where partners expressed uncertainty, such as the benefits or risks of delivery by individuals with lived experience, the compatibility of 'scare tactic' interventions with trauma-informed practice, and the effectiveness of universal knife-crime education versus its potential to heighten fear and risk perception.
- The MVRP and its partners should consider commissioning or developing internal capacity to conduct cost-benefit analyses of routine evaluation, ensuring that partners have the financial evidence necessary to inform implementation decisions.

Implementation

- MVRP and partners should consider structures to facilitate greater pooling of resources and co-commissioning, for example joint funding across local authorities to prevent duplication across borders and increase economies of scale.
- Partner organisations should look for innovative funding solutions—such as forming new multi-agency partnerships with VCSFE organisations—and consider how the MVRP's effective interventions can be adopted and scaled more systematically across the Merseyside region
- The MVRP director should sustain existing and continue to identify new relationships with engaged leaders within all partner organisations who are able to advocate within their organisational hierarchy for the public health approach, the implementation of evidence-based interventions, and a focus on early intervention. This can be supported through regular partnership meetings and communications.

Community working

- MVRP should make greater use of VCSFE organisations and community champions to capture youth and community voice in violence prevention messages and strategies by meeting the community where they already are.
- MVRP team should increase the visibility of the work undertaken by the MVRP using these community channels to help build community trust.
- Partners planning and delivering interventions must be realistic and honest with communities on what could be delivered, with recognition that overpromising could damage trust.
- Senior leaders in partner organisations should advocate for investment in youth work provision to give young people a safe place within their communities and a safety net to return to when they are at risk.

Multi-agency partnerships

- Partnership meetings, whether strategic or operational, should be guided by clear aims and underpinned by regular reporting, review membership regularly and have suitable Memorandums of Understanding (MoUs) or data-sharing agreements to improve effectiveness.
- System-level change to deliver the 'big wins' of the public health approach relies on senior leaders committing to coherent, region-wide policy and common approaches. The MVRP and steering group should draw on their networks and strategic leverage to shape and promote these policies.
- Members of the MVRP team can strengthen active partnership working by clearly communicating the MVRP vision to all partners (working in primary, secondary and tertiary prevention) and by actively widening engagement beyond traditional public-sector agencies to draw on the strengths of VCSFE groups, community members, and relevant commercial and industry partners in Merseyside.

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7. Appendices

Key features of a whole system public health approach

Table 1: Ten Key Features of a Whole System Public Health Approach (Garside et al., 2010; NICE, 2010)

Identifying a system	Explicit recognition of the public health system with the interacting, self-regulating and evolving elements of a complex adaptive system. Recognition given that a wide range of bodies with no overt interest or objectives referring to public health may have a role in the system and that therefore the boundaries of the system may be broad.
Capacity building	An explicit goal to support communities and organisations within the system.
Creativity and innovation	Mechanisms to support and encourage local creativity and/ or innovation to address public health and social problems.
Relationships	Methods of working and specific activities to develop and maintain effective relationships within and between organisations.
Engagement	Clear methods to enhance the ability of people, organisations and sectors to engage community members in programme development and delivery.
Communication	Mechanisms to support communication between actors and organisations within the system.
Embedded action and policies	Practices explicitly set out for public health and social improvement within organisations within the system.
Robust and sustainable	Clear strategies to existing resources and new projects and staff.
Facilitative leadership	Strong strategic support and appropriate resourcing developed at all levels.
Monitoring and evaluation	Well-articulated methods to provide ongoing feedback into the system, to drive change to enhance effectiveness and acceptability.