Response to Sexual Violence Needs Assessments (RSVNA)Toolkit

(Revised)

Informing the commissioning and development of co-ordinated specialist services for victims of sexual violence

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Contact Details	Stephanie Reardon National Support Team for Response to Sexual Violence Wellington House 133-155 Waterloo Road SE1 8UG www.dh.gov.uk/nst
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1. Introduction

The scale of the challenge:

- Sexual assault is a criminal offence.
- Sexual assault affects people of all genders, cultures and age groups.
- Sexual assault is commonly committed by perpetrators known by the victims, and in the case of child sexual abuse, it is often intra-familial.
- Around 10,000 women are sexually assaulted and about 2,000 women are raped every week.[1]
- As few as 11 % of those who have been raped tell the police.
- More than one third (36%) of all rapes recorded by the police are committed against children under 16 years of age.
- 16% of children under 16 experienced sexual abuse during childhood (11% of boys and 21% of girls).
- The Home Office estimates that the cost of violence against women and girls to society is around £36.7 billion. However, this does not take into account the long-term emotional and mental health problems experienced by victims or the fact that many of these crimes go unreported and undetected each year. The true cost is likely to be much higher.

Purpose of this document

1.1 The aim of this toolkit is to support local areas to begin to identify and understand the level of need of victims of sexual violence within their communities. The National Support Team (NST) for Response to Sexual Violence, who visited each of the 39 local area partnerships by police force area during 2009-2001, identified the need to support local areas in assessing the needs of victims of sexual violence.

1.2 This toolkit has been developed with advice from experts in the field of response to sexual violence, specialist services providing support to victims of sexual violence, and those who have undertaken health and public needs assessments.

[1] Self-reported, as part of the British Crime Survey

1.3 For those already familiar with needs assessments processes, but who may be new to the subject of responding to sexual violence, this document will provide a useful introduction to the subject area and key data sources to inform decision making. It includes:

- A clear description of the key steps and tasks required to conduct a thorough response to sexual violence needs assessment (RSVNA).
- An introduction to existing data sources that can inform the RSVNA.
- A summary of some methods that could be used for gathering both qualitative and quantitative data for the RSVNA.

2. The Policy Context

2.1 The Government is committed to ending violence against women and girls in partnership with key agencies and as part of empowering local communities. The cross-government strategy to support this and a response to Baroness Stern's independent review into how rape complaints are handled by public authorities in England and Wales[2], was published on 8 March 2011[3].

2.2 Tackling violence and abuse, particularly sexual violence against women and girls, requires a joined-up approach at local level through partnership with relevant stakeholders. Victims require good access to effective services, whether or not they wish to report to the police.

2.3 The NHS Operating Framework 2011/12 states that NHS organisations should properly identify women and children affected by sexual violence or abuse and ensure suitable care pathways are in place to provide sensitive, ongoing care. The framework also identifies that all acute trusts should share non-confidential information with Community Safety Partnerships in order to support reductions in the number of violence-related attendances (including domestic violence) in Accident and Emergency departments, through better targeting of local interventions to reduce violent assaults[4].

2.4 Healthcare commissioners can use the information in the NHS 2011/2012 Operating Framework to:

- Strengthen their partnership arrangements for services to victims of violence or abuse.
- Promote innovation in the services they commission to meet better the needs of victims and for greater cost-effectiveness.
- Check that they are promoting gender equality through all their commissioned services.

[2] http://www.equalities.gov.uk/stern_review.aspx
[3] http://www.homeoffice.gov.uk/publications/crime/call-end-violence-women-girls

2.5 In meeting the Government's commitment, proceeds from the Victim Surcharge will be provided to existing rape crisis centres to support stable, long-term funding. Work is also under way to establish new centres in areas where there is currently a lack of support for victims of rape and sexual assault[5] so that all victims have timely access to specialised services.

2.6 In the Taskforce report on Responding to Violence Against Women and Children – the role of the NHS (2010), Professor Sir George Alberti draws attention to the many health-related issues linked to sexual violence and abuse:

> "The NHS spends more time dealing with the impact of violence against women and children than almost any other agency. Physical and sexual violence and abuse have direct health consequences and are risk factors for a wide range of long-term health problems, including mental health problems, alcohol misuse, trauma (including maternal and fetal death), unwanted pregnancy (including teenage pregnancy), abortion, sexually transmitted infections and risky sexual behaviour. "…. more women suffer rape or attempted rape than have a stroke each year…." The same effort to ensure that a heart attack victim or a stroke patient gets rapid and appropriate care should be applied to the victims of violence and abuse."

2.7 Organisations commissioning NHS services, along with their local authority partners, have a statutory duty to undertake a Joint Strategic Needs Assessment of the health and wellbeing needs of their communities. In future, the ambition is for Health and Wellbeing Boards to go further than analysis of common problems to form deeper and productive partnerships that develop solutions to challenges (rather than just commenting on them). To support this ambition, subject to its parliamentary passage, the Health and Social Care Bill will require boards to use the Joint Strategic Needs Assessment (JSNAs) as a starting-point to develop a joint health and wellbeing strategy (JHWS) that spans the NHS, social care, public health and other sectors such as housing, that are key to addressing the wider health determinants of health. Through the strategy, local authorities, the NHS and other partners will agree, at a high level, how they will address the health and wellbeing needs of their communities, given the overarching framework for developing plans for the healthcare, social care,

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4 The operating framework for the NHS in England 2011/12. Department of Health, December 2010

public health and other relevant services. Subject to enactment, the Bill will place a legal obligation on NHS and local authority commissioners to have regard to the relevant JSNA and JHWS in exercising their commissioning functions.

2.8 There are other statutory obligations which make the RSVNA core to equitable service delivery, including the duty on public bodies to have due regard to the need to eliminate unlawful discrimination and harassment, and victimisation to advance equality of opportunity, and to foster good relations between people who share protected characteristics.

2.9 This will create a duty on public bodies to consider how their policies, programmes and service delivery will affect people with the protected characteristics, which include gender and age. The Equality and Human Rights Commission have identified violence against women as a key priority. The burden of sexual violence on women and girls means that the new Equality Duty will be a driver for specialist services, including Sexual Assault Referral Centre (SARC) services, development and improvement and the shared responsibility among partners to ensure services are co-ordinated to meet the needs of women and girls. In addition, barriers to access and disclosure and the needs of disabled people, people with learning disabilities, people with mental health problems, lesbian and transgender people will need to be considered.

2.10 In summary, a Response to Sexual Violence Needs Assessment can be a useful tool for local areas to underpin the Joint Strategic Needs Assessment, and would help to ensure that the response to sexual violence is embedded in the joint health and well-being strategy.

2.11 Excluding the needs of victims of sexual violence from a needs assessment means that these will not be understood. In such circumstances, services which were developed or delivered some time ago may remain unchallenged, even if they are unsuitable for current patterns of need. Responsive services are those that have

[5] Cabinet Office 2010; The Coalition: Our programme for government.

involvement of staff, users and relevant community stakeholders and, therefore, inclusion of the need to respond to sexual violence in the JSNA process is essential.

3. Why is a Response to Sexual Violence Needs Assessment (RSVNA) important?

3.1 As part of the JSNA process, conducting the RSVNA of the local population can lead to a better shared understanding among relevant agencies of the appropriate service response for local victims of sexual violence. The evidence and impetus created through the RSVNA will provide partners, for example from the NHS and public health, social care, police and criminal justice with the local understanding to implement effective service development or redesign that meets the needs of the community.

3.2 All areas of England have substantial numbers of individuals who have been victims of sexual violence or abuse. Many mainstream services will be dealing with individuals who are victims of sexual violence or abuse, although this may not be apparent. As such, service commissioners and providers can have a considerable impact on the lives of victims of sexual violence and (where established local partnerships are in place) they can improve the outcomes for victims of sexual violence.

3.3 Conducting the RSVNA has many benefits. It will:

- support local areas to better meet need and demand. The RSVNA provides an opportunity to gather information and refocus or design a sexual violence strategy;
- it can also support redesign or more routine services used by victims;
- enable a review of existing and related services, including those delivered by other providers such as the voluntary and community sector. This will be a helpful basis for integrated planning of service delivery;
- provide a baseline of need and current service provision, which can be used to evaluate and measure the progress of changes that are implemented;
- help to identify barriers to access and opportunities to overcome those barriers, facilitating how better access to information about services could be improved;

- help commissioners focus resources effectively and efficiently, helping to inform prioritisation when there are conflicting demands;
- stimulate more responsive services by involving staff, users and community stakeholders.

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4. Getting Started

4.1 To undertake a Response to Sexual Violence Needs Assessment (RSVNA), it is important to bring together a group of people who have a stake in the needs assessment or service provision, to consider the following questions:

- What are the aims and objectives of the RSVNA?
- Are the aims and objectives realistic in terms of current or projected resources available?
- What information is already available about victims of sexual violence?
- What are the relevant policy and priorities relating to victims of sexual violence?
- What are the remits of all the different organisations involved in responding to the needs of victims of sexual violence?

4.2 Getting the right people involved in the RSVNA is important. Ensuring the level of authority right at the start of the RSVNA process will be beneficial to ensure a clear oversight of the RSVNA.

4.3 It may be helpful to establish a Project Group for the RSVNA, which should include senior strategic and operational decision-makers from key partner organisations, able to provide leadership and facilitate the management and delivery of the RSVNA project. Alternatively, it may be appropriate to use existing groups, such as Sexual Violence (or SARC) Strategic Partnership Boards, where they exist to take on this role. Key Tasks for the Project Group include:

- Identifying the RSVNA Project Lead if undertaking the RSVNA internally
- Establish what resources are required and available for the process
- Decide on whether to commission the RSVNA internally or externally
- Prepare the RSVNA specification
- Establish agreed internal communication protocol e.g. identifying a Lead Officer to act as point of contact for external consultants if used
- Agree timelines and targets – be aware of commissioning cycles, funding opportunities and bidding deadlines
- Identify stakeholders to be included in key informant interviews
- Anticipate any barriers or threats to the RSVNA

4.4 Key informants bring a further level of intelligence to the RSVNA process. Policy makers, service commissioners, service providers, front line operational staff from the public and third sectors and service user representatives can contribute to the RSVNA process. Ideally, service users or potential service users should be included with the aim of identifying a good understanding of the local service response to sexual violence from both a supply and user perspective.

4.5 It is relevant to involve key informants in the RSVNA process through interviews or stakeholder events. Key informants for the RSVNA can include (but are not limited) to:

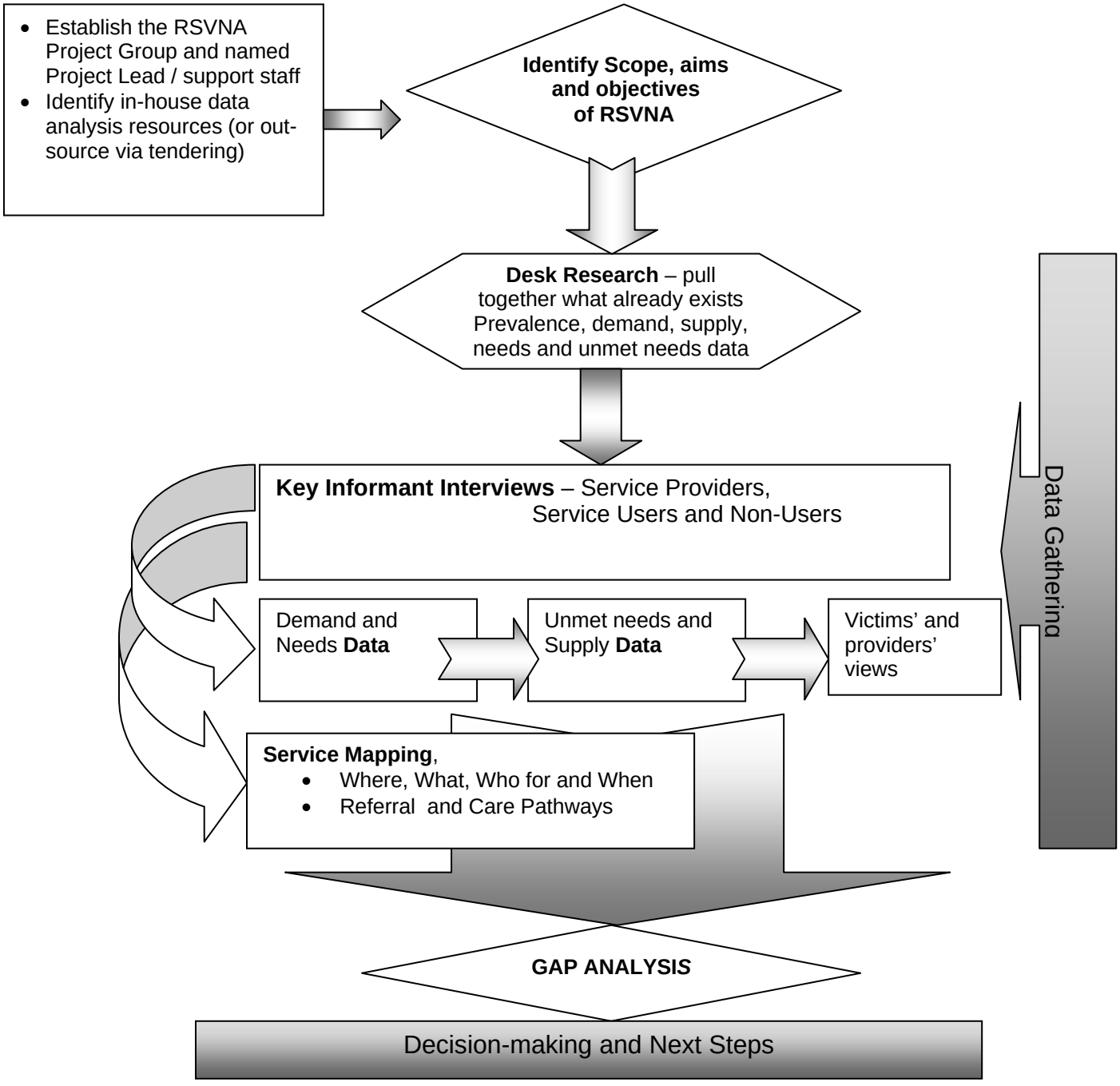
- Police
- Adult Social Care
- Children's services including services for Looked After Children
- Learning disabilities workers
- Acute NHS providers of SARC services
- GUM service consultants or nurses
- Rape Crisis and other specialist third sector providers, including children's charities
- Independent Sexual Violence Advisers (ISVAs) and Independent Domestic Violence Advisers (IDVAs)
- Safeguarding children's leads
- Further Education provider and FE practitioners
- Specialist community services
- Connexions and youth services
- Mental health services providers
- Sex workers representatives, outreach services
- Contraceptive providers
- General Practitioners
- Pharmacists
- Independent abortion providers
- (LA) colleagues such as Head of Youth Services
- Social Care Leads
- Local Safeguarding Children Boards

- Crown Prosecution Service
- Children’s Trusts
- Drug and alcohol services
- Black and Minority Ethnic (BME) representative groups
- NHS and Local Authority Commissioners

5. RSVNA Key Steps

5.1 The core elements of any Response to Sexual Violence Needs Assessment are:

- Mapping need
- Examining demand
- Mapping service provision
- Analysing the gaps
- Decision-making and next steps



Mapping Need

5.2 The RSVNA is ultimately about identifying and understanding the needs of victims of sexual violence in order to develop and establish good local services.

5.3 Examining the local population structure is essential in order to understand the scale and distribution of sexual violence and identify high risk groups. This in itself can be challenging given the under-reporting and limited data capture around sexual violence and the proportion of victims who go on to access support services. Consideration includes the nature of the needs of different service users, especially children and young people, disabled people and lesbian, gay and bisexual people and how these can be met.

5.4 The scope of the needs assessment will also include the scale and characteristics of unmet need for people who have experienced sexual violence but for a range of reasons do not access services, and therefore may not have their health and well-being and criminal justice needs met or support for utilising the criminal justice system.

Examining Demand

5.5 Demand relates to those people who require the use of services. To map demand, it is necessary to identify all types of demand through a care pathways approach. This would include the routes through which people take-up the range of services available, for example, through general practice surgeries, SARC services, voluntary and community specialist services, maternity services, abortion services, genito-urinary medicine (GUM) clinics, sexual health clinics and mental health services etc.

5.6 It is important to identify how uptake varies by population groups and service (type and location). Local engagement will yield material about those willing to use a service if none exists (or if potential users are unable to get an appointment due to phone lines only being open at certain times).

5.7 There will be a range of annonymised service data from providers about the collective characteristics and needs of people who use these services. Such data, when

analysed, will help establish existing service up-take and how closely user profiles match the levels of need identified.

Mapping Service Provision (Supply)

5.8 Mapping of local response to sexual violence services and related services across local and neighbouring areas is essential i.e. people in rural areas may more readily access services provided in nearby urban centres that may be outside the local partnership's boundaries.

5.9 At first glance, other related services may not seem relevant to the RSVNA process e.g. drug and alcohol services, sex workers outreach, young people's services such as Connexions or services through Accident and Emergency (A&E). Mapping and assessment through a care pathways approach should be made as these services may see victims and may be holding secondary information about sexual violence. Such services could be referral points in future. Mapping services provided by a range of agencies extends to the community and voluntary sector services, which support victims, some of whom may never access statutory services for this purpose.

5.10 Key issues to address are:

- Where are services currently located?
- Who is using them?
- What do the services provide (including standards and quality control)?
- When and for whom do they provide it?
- Who delivers these services?
- Which services do they refer into and receive referrals from?
- What are the outcomes for service users?
- What does it cost and what levels of investment do partners provide?

Analysing the Gaps

5.11 Once the information relating to need, demand and service provision has been gathered, a gap analysis will identify whether services are configured in the best way to meet the needs of victims of sexual violence. A gap analysis should identify:

- Mismatch in service provision (such as geographical gaps)
- Over supply
- Insufficient supply
- Mismatch in service content or delivery.

5.12 Changes to service provision as a result of duplication or omissions should be identified and prioritised to inform new or reconfigured services, new service level agreements or renewed tendering of service provision to deliver higher quality and innovative services that meet the needs of victims more effectively and efficiently.

6. Data Gathering Methods

6.1 It is an important principle that useful data does not solely comprise numbers. Data in the context of the RSVNA can also be information e.g. the location of a service or views of service users. However, without analysis (making sense of the data), its use will be limited.

6.2 There are different types of data that may be included in the RSVNA. They include data on:

- Prevalence
- Context
- Local or national sets
- Services or their evaluation
- Service maps
- Material on barriers to access
- Stakeholders who are key informants
- Service users and their friends and families

Prevalence Data

6.3 National sources of data provide information about the rates and prevalence of sexual violence among the population. In addition to numerical data, national reports provide context and background around the needs of victims of sexual violence and the extent to which many victims of such violence do not report their experience to the police or other statutory agencies.

Data source	Website	Information
General Information about Crime Data		
Criminal offences fall into several principal offence categories. Domestic violence falls across two of these categories: sexual offences and violent offences (sometimes referred to as offences against the person). All data concerning crime recording levels and the criminal justice system should be viewed with this caveat in mind. The information is obtained via a self-completion module of the British Crime Survey (BCS). Prevalence rates from this self-completion module are about five times higher than those obtained in face-to-face interviews so the figures below reflect the most accurate national picture of the scale of the domestic violence problem.		
Home Office Ready Reckoner	http://webarchive.nationalarchives.gov.uk/20100413151441/http://www.crimereduction.homeoffice.gov.uk/domesticviolence/readyreckonerv2.xls	Estimates levels of violence and abuse in various areas based on the findings of the British Crime Survey
Equality and Human Rights Commission (EHRC) online model	Under development http://www.equalityhumanrights.com/	The model will generate figures based on the assumptions that combine all the main sources of prevalence
Violence Indicator Profiles for the English Regions (VIPER)	http://www.preventviolence.info/viper/	This website provides data on violence for local authority areas across the English regions. Data provided includes hospital admissions for violence, police recorded violent crime and mortality data. Data for each local authority can be compared to regional and national averages.
British Crime Survey 2009/10	http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1210.pdf	Crime in England and Wales 2009/10. Latest findings from the British Crime Survey 2009/10 and police recorded crime.
Crime in England and Wales 2007/08; Supplementary Volume 2: Homicide, Firearm Offences and Intimate Violence 2007/08	www.homeoffice.gov.uk/rds/pdfs09/hosb0209.pdf	Home Office statistical bulletin January 2009. Contains specific information on Domestic Violence. The British Crime Survey 2008/09 contains this information within its main bulletin.

6.4 The Home Office 'Ready Reckoner' tool makes an estimate of the number of victims of sexual violence within a local area. Further age breakdowns and refinement are also possible by using national trends with local population figures. The ready reckoner can be found at http://webarchive.nationalarchives.gov.uk/20100413151441/http://www.crimereduction.homeoffice.gov.uk/domesticviolence/readyreckonerv2.xls.

6.5 The Equality and Human Rights Commission (EHRC) are developing an on-line model providing analysis of local levels of need for support by specialist services. This will identify separately the need for sexual and domestic violence services. The model will generate figures based on assumptions that combine all the main sources of prevalence data with the aim of providing reliable estimates to assist commissioners of sexual violence support services in future.

Contextual Data

6.6 Contextual data relates to the profile of the general population and communities. It will be important to understand the socio-demographic, economic and epidemiological data in order to understand their likely needs. This information will help to profile characteristics of the local population, including locations, socio-economic factors or those at higher risk.

Data source	Website	Information
Population statistics – age	www.statistics.gov.uk/statbase/Product.asp?vlnk=15106	Age profile: ONS Mid-year population estimates– latest available mid-2008
Population statistics – ethnicity	www.statistics.gov.uk/statbase/Product.asp?vlnk=14238	Ethnic profile: Includes estimates of ethnic population – latest available mid-2007

Local data

6.7 Local data sources will be available as both quantitative and qualitative data and will relate to all the core elements of the needs assessment process. In reality, all the data referred to can be gathered through local key informants. Service providers should be able to collate or generate much of the information through their databases, reporting activity or annual reports.

6.8 Desk research of reports and strategies over the last 5 years that contain local information relevant to the RSVNA should be identified by the Project Group. Along with other key informants, access to service reviews, performance monitoring exercises, patient panel consultations and other such data need to be examined before planning further data collection.

6.9 It is important to allow time and resources for existing information to be sourced and analysed for relevance. A review of existing material can inform how much additional data is required during the RSVNA process. It is therefore an important aspect of the RSVNA.

Data source	Website	Information
Police force level data	http://www.homeoffice.gov.uk/rds/ia/atlas/html http://rds.homeoffice.gov.uk/rds/soti.html	Police force-level data on recorded offences under principal offence categories by police district. Further information can be found about sexual offences data - by police force and local authority area.
Local Crime and Policing Website for England and Wales	www.police.uk	This website provides useful information about crime and policing by postcode, town, village or street and provides access to street-level crime maps and data.
Crown Prosecution Service	www.cps.gov.uk/publications/prosecution/domestic/index.html	The Crown Prosecution Service publishes a raft of general information, at national level, about domestic violence, including prosecution performance statistics and guidance.
Specialist Domestic Violence Courts	www.cps.gov.uk/publications/docs/dvpilotsites0405.pdf www.cps.gov.uk/publications/docs/specialistdvcourts.pdf	Information on Specialist Domestic Violence Courts.
Crown Prosecution Service	http://www.cps.gov.uk/publications/performance/case_outcomes/index.html	This link provides data on case outcomes.

Service data

6.10 Existing service data, for example, SARC services, specialist voluntary and community services, can assist in understanding the need, use and demand (i.e. who is currently using the service and for what purpose). This will be the primary source of demand data and can be used to analyse local 'hotspots', locations of service users and location of services.

6.11 Where services do not collect information about individual users, there should be some method of measuring volume of demand (e.g., the number of people through the door, the number of phone calls received, the number and type of referrals).

6.12 Where such data has to be collected from new, for instance a survey, this will take time. The data and the location of the services should be mapped to build a picture of service configuration, content and demand. This mapping is critical for the gap analysis exercise.

6.13 Key organisations and services can share aggregated or anonymised data to inform the response to sexual violence needs assessment. The sharing of anonymised information can be critically important to develop local understanding of the scale of sexual violence and inform commissioning of appropriate services in response.

6.14 Collecting and sharing anonymised information with police and other local partners can also support better understanding of the patterns of sexual violence in an area. Given that some victims may seek support services but also be reluctant to report to the police, sharing anonymous information can help the police to identify serial perpetrators and prevent future sexual assaults from taking place.

6.15 It is important to note that information that identifies an individual victim should not be shared, unless that individual has explicitly consented to have their information shared. There are some rare exceptions to this principle, as highlighted in the NHS

Code of Practice and associated Supplementary Guidance on Public Interest Disclosures.[6]

6.16 Service use or demand data will not identify those who are **not** accessing services or why. Some victims of sexual violence may be accessing services outside of the local area, for example via helplines,, specialist services in voluntary and community sector organisations or SARC services in neighbouring police force areas etc. Therefore, it will be important to gather information from services across the local area and where possible from services in neighbouring areas.

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122031.pdf

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

Data Source	What it can tell you	Limitations
Police	Numbers of reported incidence of sexual violence	Only 11% of those who have been raped report the incident to the police.
Sexual Offence Forensic Medical Examinations	This data will include the number of forensic examinations that have taken place. It may include incidents that may not have been reported to police - if the victim has attended SARC or non-SARC paediatric services. This data is a reliable source of information on volume of demand for forensic physicians and will include data on time of call out, day and month, which is useful for estimating fluctuations and peak demand.	Only people who have reported to the police or presented to a SARC or children examined at paediatric services around the time of the sexual assault will be included. Historic incidents will not be captured. Those not wishing to report to the police or those not attending a SARC or paediatric service will not be captured.
Voluntary and Community sector services, including children's services.	Specialist sexual violence services data provides historic incidents of abuse. Third sector data is a good source of service evaluation information as demonstrated by patients reported outcomes (PROMs). Services also record the throughput of service users and the levels of support received and will have data on referrals into the service as well as referrals onwards to other services or agencies, such as mental health services. Service users and service providers can be approached through this source to take part in key informant interviews.	Apart from referral data, data will only capture third sector service users and (although more victims will contact these services than will report to the police) there will still be gaps.
Sexual Assault Referral Centre (SARC) services	Data collected includes demographic and incident data, support needs, forensic physician attendance, police attendance and CPS information. SARC data will also record levels of ISVA contact and referral details.	SARC service data varies in quality. There is no a SARC Minimum data set, although work is underway to progress this.
Independent Sexual Violence Adviser (ISVAs)	Data collected by ISVAs includes referral information, service user characteristics, offence characteristics, non-therapeutic advice and support needs, referrals made to other agencies, criminal justice system case tracking.	The location of ISVAs (eg, in a SARC or voluntary and community sector base) will have an impact on the types of referral received and subsequently the working practices of ISVAs and data collected.
Independent Domestic	Data collected by IDVAs may	The focus of the work of IDVAs is to

Violence Adviser (IDVAs)	identity numbers of victims of both domestic and sexual violence and abuse and includes referral information, service user characteristics, offence characteristics, non-therapeutic advice and support needs, referrals made to other agencies, criminal justice system case tracking.	support victims of domestic abuse. IDVAs may collect different information depending on their location.
GUM	Genitourinary Medicine Clinic Activity Dataset (GUMCAD) data collected via GUM services (previously KC60 data) can include supplementary codes, which will record incidence of non-consensual sexual activity. As part of sexual history taking, BASHH[7] recommendations are that this information is collected.	Supplementary codes are not always used and local GUM may not have consistent data collection on sexual assault.
Other health services e.g. **Sexual Health,** **A&E,** **Maternity services** **Mental Health services** **Local abortion providers** **Pharmacists,** **Drug and Alcohol Services**	The case of *Gillick V the West Norfolk and Wisbech Health Authority and the Department of Health and Social Security* established that health professionals are justified in giving contraceptive and sexual health advice and treatment to under 16s without parental knowledge or consent. The court, however, made clear that it should be established that without that advice or treatment, the young person's physical or mental health, or both, would be likely to suffer and the young person understood the treatment and advice proposed and its implications. Issues such as whether the sexual activity was consensual must be explored. In theory, any services providing Emergency Hormonal Contraception (EHC) or other sexual health services to people under sixteen should have data on incidence of self-reported non-consensual sex. **Under Working Together guidance if non-consensual sex has been identified this states:** Where there is reasonable cause	Health services do not routinely ask service users whether the treatment they are seeking is related to sexual violence though considerable progress has been made in relation to routine enquiry in maternity and mental health services. The data may be patchy but, as part of the Violence Against Women and Children agenda, encouragement to disclose is increasing across services that are not direct sexual violence specialists.

[7] BASHH 2001 National Guidelines on the Management of Adult Victims of Sexual Assault

	to suspect that significant harm to a child has occurred, or is likely to occur, there should be a presumption that the case is reported to children's social care and a strategy discussion should be held to discuss appropriate next steps. Again, **all cases should be carefully documented** including where a decision is taken not to share information. For services that are not directly related to sexual health but where medical help is sought, victims of violence are increasingly being encouraged to disclose sexual assault.	

Service Mapping

6.17 Identifying where services are currently located is an important aspect of the RSVNA. Key informants can be used to plot and record their knowledge about the locations and content of existing sexual violence services or the related services that are accessed by victims of sexual violence e.g. domestic violence services, drug and alcohol services, third sector organisations. Some of these services may not appear to have any direct link with sexual violence services, but they may well be access points for victims of sexual violence.

6.18 A comprehensive mapping of existing services, where they are located and what services are provided will set out a baseline of relevant services.

Understanding barriers to access

6.19 Victims of sexual violence will face a range of barriers to accessing support services (both real and perceived). These barriers may include geography, infrastructure, social, cultural or confidentiality issues. Some barriers are based in the nature of the service provided, for example, services appropriateness, confidentiality, flexibility etc.

6.20 Perspectives from service users, where possible, key informants and service providers will help to identify particular barriers for victims of sexual violence to accessing services.

Key informants

6.21 The data collection aspects of the RSVNA can happen in parallel. Reports and service data can be identified directly from key informants and local service providers. Key informants include providers of services as well as community representatives and ideally service users, non-users and their representatives.

6.22 Key informants will be the main source of the data about actual service provision and content (the supply element of the RSVNA). The data enables service mapping to assess how well local services are meeting needs and how well placed they are to meet increased demand.

6.23 It may be helpful to use semi-structured interviews or short email questionnaires to explore the following with key informants:

- content and quality of local services – what works well and not so well;
- measures that would improve services;
- service users needs and how they vary;
- resource and capacity of services;
- staff numbers, roles and responsibilities;
- standards and qualifications of staff, training and staff development processes;
- governance, quality control and performance management;
- policy implications and future planning (local and national);
- referral pathways in and out of the service;
- risk management;
- identifying partners;
- funding sources;
- costs of services.

Service Users

6.24 Information about preferences and experiences can be gathered from the service provider informants listed above. Additionally, information gathered directly from victims of sexual violence who use the services, and where possible, people who have experienced sexual violence but have not used support services provides a further insight on:

- how sexual violence support services can be improved;
- how and when services are working well;
- improved understanding of barriers (real and perceived) and how to overcome them.

6.25 Given the vulnerability of service users, they may be difficult to engage. It may be possible to include their views and perspectives indirectly e.g. through feedback from Independent Sexual Violence Advisers etc.

6.26 Key questions to ask victims of sexual violence or service users are:

- Logistics and operational barriers to access (e.g. opening hours; distance; appointment system)
- Socio-cultural barriers to access
- Stigma – how it influences perception of access to health and criminal justice
- Experiences of different users to identify blockages and barriers
- What works well from their service user perspectives
- What does not work so well from user perspectives
- What support services have they used and how these might be improved
- Whether they disclosed to any service providers, who, at what stage after the attack and why
- Services they want to see.

6.27 The following methods can be useful for capturing the views of victims of sexual violence:

- Focus groups
- Suggestion boxes (in a range of locations not just at specialist services)
- One to one interviews
- Exit interviews
- Online surveys
- Feedback boards
- Facilitated service design workshops

6.28 Choice of technique is dependent upon resources and technology and the most appropriate method for the target populations. Many organisations or local authorities have a consultation department who may be able to undertake some of this work.

7. Gap analysis and identifying service opportunities

7.1 The gap analysis will review findings and equity, for example whether service configuration is fit for purpose and also meets the needs of those at greatest risk of poor health outcomes (physical or mental) and those who face the greatest barriers to service access.

7.2 Findings will need to be 'sense-checked' with the RSVNA Project Group (and key informants if appropriate). Findings form the basis for the gap analysis and inform choices and decisions as to how to improve population health and well-being in respect of treatment and preventive outcomes. This may lead to service change and redesign.

7.3 Gap analysis focuses on:

- Identifying obvious gaps in local services
- Pinpointing mismatches in service provision and service users' needs
- Examining geographical gaps, oversupply or insufficient supply
- Identifying opportunities for partnership working or new service commissioning
- Ensuring services co-ordinated in a way they can best meet needs
- Are responsive to innovation and change
- Accessibility of existing services, especially to vulnerable groups such as children
- Availability of services and impact on support for service users
- How can services be designed to meet the minimum elements[8] for SARCs
- Referral pathways in place and are understood by service partners and all relevant practitioners

[8] (2009) Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570

- Review standards and quality of local services and the effectiveness of the services and care available
- Examine where and when services may be failing to meet required standards or good practice

7.4 This analysis can highlight:

- Where information on services is not accessible to all groups
- Where need is not being met
- Where there is a mismatch in services
- Where and when there are insufficient services
- Where and when effort is being duplicated
- Where there are opportunities to support service reconfiguration

8. Decision-making and next steps

8.1 Once the RSVNA has been undertaken and key findings identified, it will be necessary to enter into a process of decision-making using the RSVNA to inform the development of recommendations and to provide evidence to support commissioning plans, allocations of resources or service redesign.

8.2 To this end, it is important that the RSVNA meet project timelines, fit budget and decision making cycles so any recommendations that are made on the basis of the RSVNA can be acted upon in a timely way.

8.3 The partnership approach to tackling sexual violence provides an opportunity to ensure that improved data standards across services can be monitored effectively. Partnerships should review the current condition, accessibility and usefulness of service data and develop agreements around future core data and usage.

8.4 Development of accessible SARC services and partnership working between police forces, health and social care, and specialist third sector services across localities will aid the journey for victims from presentation to completion of follow-up support.

Glossary

ACPO	Association of Chief Police Officers
BCS	British Crime Survey
DH	Department of Health
EHRC	Equality and Human Rights Commission
GUM	Genito-Urinary Medicine
GUMCAD	Genito-Urinary Medicine Clinic Advisory Dataset
IDVAs	Independent Domestic Violence Adviser
ISVAs	Independent Sexual Violence Adviser
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
NHS	National Health Service
NST	National Support Team
LA	Local Authority
ONS	Office of National Statistics
PROMS	Patient Reported Outcome Measures
RSVNA	Response to Sexual Violence Needs Assessment
SARC	Sexual Assault Referral Centre
VAWC	Violence Against Women and Children
VAWG	Violence Against Women and Girls