Commissioning services for women and children who experience violence or abuse – a guide for health commissioners

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Commissioning services for women and children who are victims of violence or abuse – a guide for health commissioners

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Executive summary

This guidance is designed to support health commissioners – in particular those commissioning primary care, mental health services, maternity care and sexual health services – to improve the commissioning of services for women and children who are victims of violence or abuse. Our aim is to improve the health and wellbeing outcomes for these very vulnerable people, even as the NHS goes through a period of considerable change. This guidance provides suggested outcome measures, case examples (including service specifications to download) and advice on how to include the needs of victims of violence in Joint Strategic Needs Assessments (JSNAs) – with the aim of managing the transition and developing these services in a way which will help them to adapt to the changes to the NHS and public health.

The independent Taskforce on the Health Aspects of Violence Against Women and Children recommended that we provide guidance to health commissioning organisations on how to commission services for women and children who are victims of violence or abuse. This document is a response to that recommendation. The Government recognises gender-based violence against women and girls – that is violence directed against a woman because she is a woman or because it affects women disproportionately. While specific gender differences in the prevalence of violence mean that we have focused this guidance on women, the intention is that the needs of male victims and survivors are also addressed by health services. We have included children (rather than just girls) because the expert and independent Taskforce on the NHS Response to Violence Against Women and Children decided that was more logical, as abuse disproportionately affects children irrespective of their gender.

This guidance aims to help health commissioners manage and improve these services during the transition to the new NHS structures. It has a strong focus on outcomes – though we cannot pre-empt the decisions the NHS Commissioning Board will make about the Commissioning Outcomes Framework – and is designed to support PCTs and in particular GP Consortia as they take on increasing responsibilities throughout 2011/2012.

Commissioners can use this guidance, and the resources available at www.pcc.nhs.uk/violence to:

- Identify what range of services for women and children who are victims of violence they are currently commissioning, both as individual organisations and through their Local Strategic Partnership (LSP)
- Work with service users and local specialist organisations to inform all parts of the commissioning cycle
- Use local and national data to identify local needs, and feed these in to their Joint Strategic Needs Assessment (JSNA)
- Start using (or increase the use of) outcome measures and social return on investment techniques to help identify effective and ineffective services and those which give best value for money, and re- or decommission accordingly

On a practical level, all the organisations mentioned as examples of good practice in this document have kindly agreed to share their:

- Service specifications
- Service Level Agreements
- Datasets

These are all available for copying and adaptation at www.pcc.nhs.uk/violence.

1. Introduction

The Coalition Government is committed to addressing violence against women and girls, specifically the Coalition Agreement[1] says the Government will:

- deliver up to 15 new rape crisis centres
- give existing rape crisis centres stable, long-term funding.
- investigate a new approach to helping families with multiple problems

Call to End Violence Against Women and Girls (2010)[2] provides a strategic framework which sets out the Government's work in this area over the next four years. This will be followed in spring 2011 by a detailed set of supporting actions which focuses on preventing violence from happening in the first place. The Government will also respond to Baroness Stern's independent review into how rape complaints are handled by public authorities in England and Wales[3]. The Home Office has also committed to continuing to contribute to the training and the quality assurance process for Multi Agency Risk Assessment Conferences (MARACs) to assist in ensuring levels of consistency across the country and help disseminate good practice.

Violence or abuse – physical, sexual, emotional, financial – against women and children happens everywhere. No one group is immune – regardless of socio-economic status, age, ethnic group or sexual orientation.[4]

[1] Cabinet Office 2010; The Coalition: Our programme for government.
[2] www.homeoffice.gov.uk/vawg
[3] http://www.equalities.gov.uk/stern_review.aspx
[4] British Crime Survey 2009/10.

The statistics

- More than one in four women (4.8 million) aged between 16 and 59 have been affected by domestic abuse.
- 40-50% of women who have experienced domestic violence are raped within their physically abusive relationship.
- 3.2 million women aged between 16 and 59 have been sexually assaulted since the age of 16.
- The cost of violence against women and children runs into billions of pounds. Costs include the costs of providing public services for victims, the lost economic output of women and the human and emotional costs of violence for victims. An indicative figure for the minimum cost of violence against women and children is £36.7bn.
- Around one in five rapes recorded by the police are committed against children under 16.
- 50% of women in prison report domestic violence and one third report sexual abuse
- Almost one eighth (12.4%) of lesbian/bisexual women have been victims of partner abuse (non-sexual).

When we add to this trafficking, forced marriage, female genital mutilation, (so-called) honour-based violence, forced prostitution and sexual harassment at both work and in public spaces – as well as significant under-reporting – we are looking at a significant proportion of UK women having experienced some form of gender based violence or abuse.

Details of statistics in box in footnote[5]

Violence can take many forms – we have included detailed descriptions of the main types of violence experienced by women and children in Annex C. For example, domestic abuse may involve physical violence, or controlling behaviour such as not allowing a woman to leave the house, or not allowing her access to money or to a phone. Commissioners with little experience of services for victims of violence and abuse may well find it useful to identify a local expert – often from the voluntary sector – who will be able to help identify and explain the types of violence and abuse most prevalent in their local area.

The NHS is in a period of rapid change, but women and children affected by abuse and violence will continue to require services. The Operating Framework 2011/12 states that NHS organisations should ensure that they properly identify these patients and have suitable care pathways in place to ensure that they get the sensitive, ongoing care they need. In addition, all acute trusts should share non-confidential information with Community Safety Partnerships in order to support reductions in the number of violence (including domestic violence) related

[5] Box, bullet 1 – British Crime Survey 2009/10.
Box, bullet 2 – Martin, E. K., Taft, C. T., & Resick, P. A. (2007). A review of marital rape. Aggression and Violent Behavior, 12(3), 329-347.
Box, bullet 3 – British Crime Survey, 2009/10
Box, bullet 4 –.Home Office, 2010
Box, bullet 5- British Crime Survey 2009/10
Box bullet 6– Social Exclusion Unit (2002) Reducing re-offending by ex-prisoners. London. HMG Cabinet Office
Box, bullet 7– British Crime Survey, 2009/10

attendances in A&E departments, through better targeting of local interventions to reduce violent assaults[6].

Healthcare commissioners can use the Operating Framework to:

- Strengthen their partnership arrangements for services for women and children who are victims of violence or abuse
- Promote innovation in the services they commission, in order to better meet the needs of this group and become more cost-effective
- Check that they are promoting gender equality through all their commissioned services

The findings of the Munro Review of child protection will be completed in April 2011. The response to this review is likely to impact on the way the NHS contributes to safeguarding children. In the meantime and throughout the transition period, the NHS should continue to build on the improvements to date in this area and ensure that statutory duties, as set out in the statutory guidance *Working Together to Safeguard Children*[7], and partnership working arrangements are maintained and handed over to new organisations in good order.

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

[7] Working Together to Safeguard Children http://publications.education.gov.uk/eOrderingDownload/00305-2010DOM-EN.pdf 23

2. Definitions

CEDAW definition of violence against women

Across Government we have adopted the United Nations' Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) definition of violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life'. We are clear across Government that such violence includes that committed at home or in public spaces, and that the term 'women' includes girls. In this document, we have included boys as well as girls, to match the Taskforce's remit[8].

The Committee on the Elimination of Discrimination Against Women (CEDAW) views gender-based violence as a form of discrimination that constitutes a serious obstacle in the enjoyment of human rights and fundamental freedoms by women, and addresses the way gender-based violence interacts with the different areas covered by the articles of CEDAW. Violence against women includes:

- Violence in the family – such as domestic violence, partner rape; incest; forced prostitution by the family or partner; violence against domestic workers and the girl-child (non-spousal violence, violence related to exploitation), forced pregnancy, forced abortion; sex-selective abortion and infanticide; practices such as female genital mutilation; dowry-related violence; and religious/customary laws
- Violence in the community – such as rape/sexual assault; sexual harassment; violence within institutions; trafficking and forced prostitution; violence against women migrant workers; and pornography
- Violence perpetrated or condoned by the state – such as gender-based violence during armed conflict; systematic rape, sexual slavery, custodial violence; violence against refugees and internally displaced persons; and violence against women from indigenous and minority groups.

UNCRC definition of child abuse

The UK is a signatory to the United Nations Convention on the Rights of the Child (UNCRC), and so has committed itself to "protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for

[8] Department of Health. (2010). Report of the Taskforce on the Health Aspects of Violence Against Women and Children. Available at www.dh.gov.uk/en/Publichealth/Healthimprovement/ViolenceagainstWomenandChildren/Taskforce/index.htm

identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement."[9]

Under the UNCRC, Governments are also expected to "take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration [should] take place in an environment which fosters the health, self-respect and dignity of the child.".[10]

Domestic violence – definition

The Government defines domestic violence as "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality." This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

Domestic violence can take many forms including psychological / emotional abuse, physical violence, physical restriction of freedom, sexual violence and financial abuse. A term which is increasingly used to refer to domestic violence is 'domestic abuse', which has the advantage that it reflects the non-physical abuses referred to above. The main characteristic of domestic violence is that the behaviour is intentional and is calculated to exercise power and control within a relationship. For further information, see http://www.equalities.gov.uk/

Sexual violence against women – definition

Rape and other sexual assaults are sexual acts carried out without the consent of one of the people involved. Under the Sexual Offences Act 2003:

- Rape is classified as penetration by the penis of somebody's vagina, anus or mouth, without their consent. Rape can be committed against men or women, but since it involves penile penetration it is only committed by men.
- Assault by penetration – it is an offence to penetrate the anus or vagina of someone else with any part of the body or with an object, if the penetration is sexual and if the person does not consent.
- Sexual assault – the law also covers any kind of intentional sexual touching of somebody else without their consent. It includes touching any part of their body, clothed or unclothed, either with your body or with an object.
- Causing a person to engage in a sexual activity without consent – any kind of sexual activity without consent. For instance it would apply to a woman who forces a man to penetrate her, or an abuser who makes their victim engage in masturbation.

Sexual abuse against children – definition

[9] United Nation. Convention on the Rights of the Child. Available at http://www.unicef.org/crc/
[10] www2.ohchr.org/english/law/crc.htm

Government guidance, Working Together to Safeguard Children[11], defines child sexual abuse as forcing or enticing a child or young person under 16 years old to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

DCSF guidance published in November 2009 defines sexual bullying as bullying behaviour that has a specific sexual dimension or a sexual dynamic and which may be physical, verbal or non-verbal / psychological. Behaviours may involve suggestive sexual comments or innuendo including offensive comments about sexual reputation; or using sexual language that is designed to subordinate, humiliate or intimidate. It is also commonly underpinned by sexist attitudes or gender stereotypes. Sexual bullying can be seen as sexual harassment in the schools. Both sexual and transphobic bullying may affect boys and girls[12].
As many people choose not to disclose the violence or abuse they have experienced for a number of years or at all they are often considered to be victims of historic abuse. These offences are covered by the above definitions.

Harmful practices and trafficking – definitions

Forced marriage

A forced marriage can be defined as: "a marriage in which one or both spouses do not (or in the case of some adults with support needs, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure."[13] Women are disproportionately affected by forced marriage (86% of cases)[14], and women may be subjected to repeated rape (sometimes until they become pregnant). Individuals who attempt to avoid being forced into marriage, or who run away from such a marriage, can be at risk of serious violence or even murder[15].

Honour-based violence

Honour-based violence is any type of physical or psychological violence committed in the name of 'honour' predominantly against women for actual or perceived immoral behaviour, which is deemed to have shamed their family or community. The most extreme form of such violence is so-called 'honour killing'.[16] So-called honour-based violence is rooted in unequal and unjust gender relations where women are denied the right to exercise choice and control

[11] NSPCC definition (adapted from the definition provided by WOMANKIND Worldwide)
[12] Safe to Learn: Guidance for schools on preventing and responding to sexist, sexual and transphobic bullying DCSF (December 2009)
[13] HMG (2008), *The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage* available at www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage
[14] www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage
[15] For further information see www.equalities.gov.uk/PDF/Forced_Marriage_factsheet_final.pdf
[16] (Metropolitan Police).

over their own lives. 'Honour' crimes and killings are an abuse of human rights, and are not excused by religion, ethnicity or culture.

Female Genital Mutilation (FGM)

FGM comprises all procedures involving the partial or total removal of the female external genitals or other injury to the female genital organs for non-medical reasons[17]. Those procedures have no health benefits for girls and women and can cause bleeding, infection and urinary difficulties as well as long term psychological, gynaecological and obstetric complications and newborn deaths. In the UK, the Female Genital Mutilation Act 2003 outlaws the practice in the UK and, for the first time, makes it an offence for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal.[18] For further information, see www.fco.gov.uk/fgm.

Human trafficking

The United Nations definition of human trafficking is "the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation."[19] The above definition has informed UK domestic law criminalising human trafficking via the Sexual Offences Act (2003), the Criminal Justice (Scotland) Act 2003, and the Asylum and Immigration (Treatment of Claimants) Act 2004.

[17] World Health Organisation (2008)
[18] http://www.homeoffice.gov.uk/about-us/home-office-circulars/circulars-2004/010-2004/
[19] Article 3 of the Palermo Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the UN Convention against transnational organized crime (2000).

3. The role of commissioners

Commissioners of services – particularly primary care, mental health, sexual health and maternity services – can have a real impact on the lives of women and children who are, or have been, victims of violence or abuse.

- All areas have a substantial number of women and children in their population who are, or have been, victims of violence or abuse.
- All mainstream services deal with women and children who are victims of violence or abuse without recognising that they are doing so.
- PCTs already have the partnerships in place to make a real difference. GPs and other health commissioners will be in a strong position to build upon these.
- It is more cost-effective to prevent or stop violence than it is to deal with the long-term consequences.
- Public bodies are bound by national and international law to have due regard to the need to eliminate unlawful discrimination and harassment, and promote equality (the Gender Equality Duty, soon to be the integrated public sector Equality Duty) as well as to protect children's rights through the UN Convention on the Rights of the Child.
- Public bodies are bound by law to safeguard children and vulnerable adults.
- Organisations commissioning NHS services, and their local authority partners, have a statutory duty to undertake Joint Strategic Needs Assessments of the health and wellbeing needs of their communities.

Cost of healthcare for women who are victims of domestic violence

Women who have suffered domestic violence have approximately twice the level of usage of general medical services and between three and eight times the level of usage of mental health services. The estimated cost (including hospitals, ambulances, GPs and prescriptions) is £1.7bn.

It is estimated that the cost of treating depression in women who have experienced domestic violence is £10.3m (though this figure is based on data from the early 1990s, so it is likely that the actual figure is higher). The cost of providing an IDVA for a high risk victim of domestic abuse is around £500, and the cost per successful outcome (ie where all forms of abuse stop) is less than £1000 – though cessation of abuse does not necessarily mean that mental health problems cease as well.

This does not include the role that specialist services can play in reducing abuse, and thus costs on other services such as health and housing.

Details of statistics in box in footnote[20]

[20] Box, 1st para – Walby, S. (2008). The Cost of Domestic Violence. Women and Equality Unit. London.
Box, 2nd para – Howarth, E., Stimpson, L., Barran, D. and Robinson, A. (2009) Safety in Numbers: A Multi-Site Evaluation of Independent Domestic Violence Advisor Services.

The scale of the problem

In the average PCT, GP practice or Local Authority, the official statistics (which are likely to be an under-estimate) show that:

- 29% of the female adult population aged 16-59 have been a victim of domestic violence since the age of 16[21]
- 4% of women aged 16-59 will have been raped since the age of 16 (excluding those who have been subjected to attempted rape)[22]
- 6% of the children on local Child Protection Registers will have suffered sexual abuse[23]

There is great variability in the response of local services to women and children who have been victims of violence or abuse.

Type of Violence	Female	Male	Source and location of study
Child Sexual Abuse (all forms and contact abuse)	21% all forms 16% contact abuse	11% all forms 7% contact abuse	(Cawson et al, 2000) United Kingdom
Child physical abuse (violent treatment from anyone)	23%	27%	(Cawson et al, 2000) United Kingdom
Child Emotional Abuse (humiliation by parents)	20%	16%	(Cawson et al, 2000) NSPCC UK study
Bullying (10-15 year olds)	39%		(OFSTED 2008) England
Youth violence (16–24 year old victims of violent crime in last year)	4%	13%	British Crime Survey 2009/10 England & Wales
Youth violence (16–24 year old victims of violent crime in last year)	4%	13%	British Crime Survey 2009/10 England & Wales
Partner abuse (non-sexual) (16–59 year olds experienced since the age of 16)	23%	11%	British Crime Survey 2009/10 England & Wales
Stalking	19%	9%	British Crime Survey 2009/10 England & Wales
Forced marriage	In 2009, the Forced Marriage Unit gave advice or support to 1682 cases. 86% involved females and 14% involved males.‡		(HMG 2009b) United Kingdom

[21] British Crime Survey 2009/10
[22] Ibid
[23] Referrals, Assessment and children and young people who are the subject of a child protection plan, England, Year ending 31 March 2009. DFE. Available at: http://www.education.gov.uk/rsgateway/DB/STR/d000959/index.shtml

'Honour'-based violence	No published UK statistics. In 2009/10, there were a total of 477 allegations of honour-based violence. In12% of these allegations, the victim was aged under 18.[+]	(Metropolitan Police Service 2010) Greater London (excluding City of London)
Female Genital Mutilation (FGM)	In 2001, an estimated 66,000 women in the UK had been affected by female genital mutilation (FGM) at some point in their lives, and around 16,000 girls under 15 years old were at risk of the most severe type of FGM.	(FORWARD 2007) England & Wales

[‡] Note there are no reliable estimates on the extent of forced marriage in the UK.

[+] Note these are the number of allegations recorded. The real figures are likely to be far higher.

Many organisations are involved in helping women and children who are victims of violence or abuse. It is worth assessing whether your organisation could do more to address the needs of these women and children.

Below are **some of the obstacles to health services working well with their partners** to tackle violence against women and children:

- Many health commissioners have little knowledge of local services for, or the health needs of, women and children who are victims of violence.
- Many health commissioners are unsure who is / should be responsible for commissioning services from outside the public sector.
- Health practitioners and their host organisations can be reluctant to share information, due to concerns about confidentiality, even where this is appropriate. Sometimes appropriate sharing of information can prevent further harm to victims (see box on next page).
- Health practitioners may refer or signpost victims to services provided by voluntary and community organisations or social enterprises without contributing to the cost of delivering these services or engaging in the co-ordination of care across organisational or geographical boundaries.
- Some NHS staff are unable to contribute to Multi-Agency Risk Assessment Conference (MARAC) meetings because of lack of support from their host organisation or lack of capacity.
- Service commissioners may be unclear of the difference between a SARC and a specialist sexual violence service such as Rape Crisis Centres (RCCs), and many health commissioners do not engage in joint commissioning and funding of the local SARC.

Information sharing – the law

The key guidance material on information sharing includes the following documents:

- the General Medical Council's guidance *Confidentiality* (GMC 2009)
- supplementary guidance and *0-18 years: guidance for all doctors* (GMC 2007)
- *The NHS Code of Practice on Confidentiality* (2003) – which includes supplementary guidance on public interest disclosure that is currently being revised
- *HM Government Information Sharing: Guidance for practitioners and managers* (2008)

Confidentiality, subject to the requirements of the law, is clearly an essential part of both ethical clinical practice and key to developing the trust of service users who may want to disclose abuse. This is not simply about following the rules, it is also critical that practitioners are able to explain clearly to women and children what their choices are, and what information practitioners are legally obliged to pass on. This includes an understanding of the rules relating to competence and children. The question of whether a health practitioner may need to consider sharing information even when it is not possible to obtain consent rests largely on whether or not disclosure can help to detect, prosecute or prevent a 'serious crime'. The Violence Against Women and Children Taskforce found that there is a need for greater clarity on where public interest disclosure applies.

However much guidance exists, it is clear from the myriad examples relayed to us in the consultation conducted in 2009/10 that every case is unique. It is therefore essential for each case to be looked at on its merits and the individual risks of sharing information weighed up against the possible consequences (for the woman or her children) of not sharing. The algorithms set out in key guidance should be widely available, and followed and women given an explanation in every case where it is considered necessary to disclose without her consent. The Taskforce also recommended that health practitioners should be supported by Trusts to make the right decisions about information sharing based on the specific details of individual cases and interpretation of relevant guidance

Information sharing – what victims told us

A key message from the Violence Against Women and Girls consultation was "that statutory sector providers wanted greater automatic information sharing between agencies with significant numbers recommending a mandatory duty. Survivors and the voluntary sector, however, tended to express concern over the increased potential for confidentiality breaches, stigmatising labels being attached to victims and for disclosure to lead warnings that their children may be removed. Many survivors gave personal examples of information sharing between professionals negatively affecting their situation and were concerned that further moves would result in fewer disclosures. Much of the mistrust appears to centre on the fact that most victims of violence and abuse do give their consent for the sharing of information when asked. As such, calls for new legislation or guidance by some agencies, can give rise to the suspicion that services want to be able to share information without the requirement of victim consent. It is therefore important to be very open with women about what information will be shared in their particular circumstances.

Commissioners can be reluctant to fund women-only services, based on a misunderstanding of the Gender Equality Duty. This is part of a wider misunderstanding in which some health commissioners make commissioning decisions based on equity (ie the same for all) rather than equality and diversity (ie different services to meet different needs)[24]. This document aims to clarify the law in the box below:

[24] NICE definition – health inequality describes ***differences in health experience and health outcomes*** between different population groups – according to socioeconomic status, geographical area, age, disability, gender or ethnic group. In contrast, health inequity describes ***differences in opportunity*** for different population groups which result in unequal life chances, access to health services, nutritious food, adequate housing and so on. These can lead to health inequalities. PCTs need to focus on ***how fairly resources are distributed in relation to the health needs of different groups***. (This may include resources such as services, facilities, and the determinants of health like employment and education). The overall aim is not to distribute resources equally, but rather in relation to need. Changes in investment and services as a result of health equity audits will aim to reduce avoidable health inequalities and promote equal opportunity to the determinants of good health, access to health and other services.

What are the Gender Equality Duty and the Equality Act 2010?

The Gender Equality Duty came into force in England, Scotland and Wales in April 2007 and requires public authorities to:

- promote equality of opportunity between men and women and
- eliminate unlawful harassment and sex discrimination, including against transsexual people.

The duty requires public authorities to identify and take action on the most important gender equality issues. The duty also applies to other organisations, including within the private and voluntary sectors, which are exercising public functions. This could include, for example, organisations that run private prisons; however, the duty would not apply to any of the organisation's work not connected with the public function of running the prison.

Guidance from the Equality and Human Rights Commission specifies that the duty does not mean single-sex services should be cut, have funding withdrawn or that any new services should not be funded. Neither does it mean that services should necessarily be provided on the same scale for both men and women. Single-sex services are permitted under sex discrimination law, and moreover are necessary in order to properly meet the needs of victims in such cases. Equally, specific services for particular minority and protected groups should be encouraged where they are needed to properly meet the needs of the local community. Again, discrimination legislation does not prevent commissioners from selecting specialist providers. For example, services for ethnic minority women have been important in promoting race and gender equality by improving access for women who face linguistic, economic and cultural barriers.

Lord Justice Moses, in the case of Southall Black Sisters versus Ealing Council, ruled that: 'There is no dichotomy between funding specialist services and cohesion; equality is necessary for cohesion to be achieved.'

The Equality Act 2010 provides a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all. The majority of the Act was commenced on 1st October 2010. Until April 2010 the Gender Equality Duty will continue to place public authorities (including the Department of Health and NHS bodies) under a legal obligation to identify and take action on the most important gender equality issues, including VAWC. The Duty also applies to other organisations, including within the private and voluntary sectors, which are exercising public functions (for example delivering VAWC services). From April 2011, the Equality Duty (which will cover all the protected grounds: age, disability, gender, gender reassignment, pregnancy and maternity, race, religion and belief and sexual orientation) will continue the requirements currently set out by the Gender Equality Duty, and will introduce a requirement for public authorities to have due regard, when exercising their functions, to the need to foster good relations between men and women.

More information can be obtained from the Government Equalities Office.

Mainstream services

Many mainstream services are essential for the care, treatment and recovery of women and children who are victims of violence or abuse. Health commissioners are involved in these services every time they commission or provide:

- **Primary care services** – primary care is often the first point of contact, with 20% of women saying they would turn to their GP if they or someone they knew was a victim of abuse or sexual violence (second only to going to the police, at 31%).[25] Primary healthcare is often the first point of contact for people seeking help. Routine enquiry about violence or abuse is being rolled out in NHS maternity services, but this does not always identify the needs of victims of violence and the long term, far reaching impact of violence or abuse. A key theme which emerged from the Home Office's Violence Against Women and Girls (VAWG) consultation was that both stakeholders and victims supported routine enquiry across key health services. However, many respondents stated that despite the Department of Health supporting routine enquiry in maternity services since 2005, it is not being done consistently[26]. Feedback from health care practitioners reinforces this evidence, and suggests that questions about violence or abuse are sometimes not asked in health care settings because staff are not sure what they would say if someone is experiencing violence or abuse, nor where to refer them on to (ie there is no local care pathway).
- **Ambulance services, A&E departments and dentists** all deal with the physical results of domestic and sexual violence
- **Community services** – Health Visitors see all families with a new baby and support families with children under 5 years old. Health Visitors can build up a relationship with families that need additional support
- **Maternity services -** Midwives work with pregnant women – and pregnancy is a risk factor for domestic and sexual violence and is prioritised in the CAADA DASH risk identification checklist[27]. Midwives are trained in routine enquiry and screening for domestic violence.
- **Children's services**, including school nurses and Children's Centres
- **Mental health services**, including Child and Adolescent Mental Health Services (CAMHS), deal with many women, young people and children who currently are, or have been, victims of violence or abuse – and are rolling out routine enquiry into experiences of past and current violence or abuse in all mental health assessments
- **Female Genital Mutilation (FGM) clinics** – these have been set up in areas with populations at highest risk
- **Sexual and reproductive health, genitourinary medicine (GUM) and community contraceptive services (CCS)** – provide contraception, emergency access to contraception, Post-Exposure Prophylaxis (PEP) for HIV, testing and treatment for sexually transmitted infections and termination of pregnancy for victims of acute and/or historic abuse. Surveys show around 46% of female GUM attendees and 35% of CCS attendees reported having been victims of historic sexual assault[28]. These services are therefore key

[25] Department of Health. (2008). Report of the National Patient Choice Survey.
[26] p.90 of Home Office VAWG strategy 2009
[27] Coordinated Action Against Domestic Abuse. Domestic Abuse, Stalking and 'Honour'-based Violence Risk Identification (DASH) Checklists. Available at www.caada.org.uk/practitioner_resources/riskresources.htm
[28] Loke, W., Bacchus, L., Torres, C. and Fox, E. (2008). Domestic Violence in a genitourinary medicine setting – an anonymous prevalence study in women. International Journal of STD and AIDS, 19(11), 747-751.

in identifying and treating women and young people who are victims of either current or historic abuse , whether or not that is their reason for attendance. As part of service specifications, commissioners should, where appropriate, identify the interdependencies between the range of sexual health providers, sexual assault referral centres and domestic abuse support services.

- **Specialist gynaecology services** for the management of complications affecting victims' eg reproductive potential
- **Prison health services** for female and young offenders
- **Specialist alcohol and drug treatment services**

The rate of violence or abuse is so high – around 29% of adult women aged 16-59 have experienced domestic abuse since the age of 16[29] – that these services deal with substantial numbers of women and children who are victims of violence or abuse every day. In fact, despite often finding it hard to access services, victims of violence or abuse tend to use health services more than average (see box below). So it is in the NHS interest to identify these women and children, provide opportunities for them to disclose, and provide services where necessary to help them improve their physical and mental health. When commissioning universal services, such as the healthy child programme and maternity services, health commissioners will want to consider how these services will support the processes related to violence or abuse, such as MARACs, as well as the individual victims.

Routine enquiry

Routine enquiry is being implemented in key parts of the health sector. Midwives are trained to ask sensitive questions during the booking process to find out whether a woman is subject to domestic abuse. This information contributes to the full health, social needs and risk assessment, usually undertaken by the twelfth completed week of pregnancy. National mental health policy on violence and abuse (mental health) to improve the care and support provided by survivors – underpinned by routine enquiry of abuse in child and/or adulthood in assessments – is currently being implemented in all mental health provider trusts.

Because these are mainstream services, commissioners may not recognise the valuable work they are doing with victims of violence or abuse, or the care pathways involving specialist services to which mainstream services refer women and children. When taking decisions about the types of services needed in their area, health commissioners should take into account the need for services that are focused on support, and safe spaces for women to recover their dignity and autonomy, and the impact of their re- or decommissioning decisions on victims of violence or abuse. In particular, commissioners should be aware of the importance of clear referral pathways, so that health professionals know where and how to refer women and children to local services.

[29] British Crime Survey 2009/10

Research tells us that poor health outcomes are associated with domestic and sexual violence

- Chronic physical health problems such as irritable bowel syndrome, backache and headaches (Campbell, 2002).
- Sexual and reproductive health problems, such as increased rates of unintended pregnancies (including teenage), terminations (Gazmararian et al, 2000), and low birth weight babies (OR 1.4, 95% CI 1.1-1.8) (Murphy et al 2001), lower rates of contraceptive use, higher rates of sexually transmitted infections, including HIV (Garcia-Moreno and Watts 2000), partner's refusal to use contraception or control over contraception (Williams et al, 2008), sexual risk-taking behaviour and loss of sexual decision making capacity (Coker 2007).
- For children, increases in short and long-term anti-social behaviour such as missing school, getting into fights, and cruelty to animals; mental health problems; depression; anxiety; substance misuse and suicidality, (Shipway, 2004; McFarlane *et al*, 2003; Roberts, 2003).
- 500 women who have experienced domestic violence in the last six months commit suicide every year. Of these, just under 200 attended a hospital for domestic violence on the day they committed suicide. (Walby, S 2004 The Cost of Domestic Violence)

Details of statistics in footnotes[30]

This means that health commissioners need to be explicit about the role mainstream services play in supporting women and children who are victims of violence or abuse, and reflect this in their commissioning – including seeking assurance that providers ensure that staff are appropriately trained to identify and deal with victims of violence or abuse. This is most effectively done by working with other organisations, and a great deal of successful work in this area has been in the form of partnership working between health organisations, Local Authorities, charities and the police – and with women and children themselves. This should include people with different backgrounds and circumstances (age, physical, learning and psychological disabilities, ethnic groups, religion or belief, sexual orientation, gender identity and socio-economic groups) to ensure their specific needs are taken into account.

[30] Box, 1st bullet - Campell, J.C. (2002) Health consequences of intimate partner violence. Lancet 359(9314),1331-6.
Box, 2nd bullet – Gazmararian, J., Lazorick, S., and Spitz ,A. (1996). Prevalence of violence against pregnant women: a review of the literature. JAMA 275, 1915–20; Murphy CC, Schei B, Myhr TL, Du Mont J. (2001). Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. Can Med Assoc J 164: 1567–72.
Box, 3rd bullet – Ibid; Garcia-Moreno C and Watts C. 2000. Violence against women: Its importance for HIV/AIDS. AIDS. 14 (3), 253-265; Williams, C. Larsen, U., and McCloskey, L.A. (2008). Contraceptive use among abused women.Violence against Women, 14 (12), 1382-1396. Coker, A. (2007). Does Intiamte Partner Violence Affect Sexual Health? A systemic review. Trauma Violence and Abuse, 8(2), 149-177.
Box, 4th bullet - Howard L., Trevillion K., Khalifeh H., Woodall, A., Agnew-Davies, R. and Ferder, G. (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychological Medicine40, 881–893 .
Box, 5th bullet – Shipway, L. (2004). Domestic Violence: A handbook for health. Routledge. McFarlane, J., Groff, J. O'Brien, J. and Watson, J. (2003). Children who are exposed and not exposed to intimate partner violence: An Analysis of 330 Black, White, and Hispanic Children Behave. Pediatrics, 112(3), 202-207; Conners,, M. Bradley, R.Whiteside, L., Liu, L. Roberts, T. and Herrell,, J. (2003). Children of Mothers with Serious Substance Abuse Problems: An Accumulation of Risks. The Americal Journal of Drug and Alcohol Abuse, 29(4), 743-758.
Box 6th bullet – valby, S. (2004). The Cost of Domestic Violence. Lancaster University.

The high correlation between violence and mental and physical ill-health, plus the positive results of working in partnership, make it even more important that the NHS recognises and acts upon its responsibilities in this area, particularly as we enter a period where greater constraint on resources across the public sector will make working across traditional boundaries more important than ever.

Partnerships

Joint working and Local Authorities

Local Authorities (LAs) traditionally commission services for women and children who are victims of violence or abuse by providing services for children through their children's social care departments, as well as commissioning for both women and children through grants, Sure Start and Supporting People funding. There is an existing infrastructure for these services, largely provided by charities rather than statutory organisations:

- Women's refuges and specialist domestic violence services – run by charities such as Women's Aid and Refuge, often funded by Las. these services are backed up by the National Domestic Violence Helpline[31]
- Sexual Assault Referral Centres – largely funded by police, some also have NHS funding. Often run by the statutory sector, though they frequently refer on to specialist services in the voluntary sector.
- Black and minority ethnic services for women, including advocacy services – run by charities such as Imkaan and Southall Black Sisters, often funded by LAs
- Generic counselling and victim support services – run by charities such as NSPCC, Relate and Victim Support with some LA funding, occasionally NHS funding and (in the case of Victim Support), central Government funding
- Rape crisis centres and sexual violence services – part of specialised networks such as Rape Crisis or the Survivors Trust, with some LA and NHS funding
- Family support and specialist child sexual abuse services – provided by Barnardos, Action for Children, NSPCC with some LA funding

The role of joint working and Health and Wellbeing Boards

At present, PCTs not only commission services for women and children who are victims of violence or abuse directly, but work through their Local Strategic Partnerships (LSPs) with other organisations to commission services working with the local:

- Community Safety Partnerships (CSPs – these are currently under review)
- Drug Action Teams (DAT) and Drug and Alcohol Action Teams (DAAT)
- Children's Trust Board
- Local Safeguarding Children's Board
- Schools
- Housing services
- Adult social services and Children's services
- Director of Public Health
- Communication teams (on the unacceptability of violence and availability of help)

[31] http://www.nationaldomesticviolencehelpline.org.uk/

Mechanisms to support joint working

The framework provided by the National Health Service Act 2006 allows money to be pooled between health bodies and health-related local authority services and for functions to be delegated and resources and management structures to be integrated between Local Authorities and NHS bodies. The arrangements allow commissioning for existing or new services, as well as the development of provider arrangements, to be joined up. These legal powers were previously referred to as Section 31 Health Act flexibilities, although they are now to be found in section 75 of the NHS Act 2006, and cover:

- lead commissioning
- integrated provision
- pooled budgets.

Any references to section 31 in regulations or guidance should now be read as a reference to section 75. The content of the guidance is equally applicable. More detail can be found at www.dh.gov.uk/en/Healthcare/IntegratedCare/HealthAct1999partnershiparrangements/index.htm

- Charities (both specialised eg refuges and general eg housing associations)

The Health and Social Care Bill also includes a provision to establish a statutory Health and Wellbeing Board in each top-tier Local Authority. Health and Wellbeing Boards will bring together local NHS, public health and social care commissioners, elected representatives and representatives of HealthWatch to discuss how to work together to better the health and wellbeing of the people in their area.

Through new boards, local government and commissioning consortia will work together to understand local needs through a joint strategic needs assessment (JSNA) and to create a joint health and wellbeing strategy (JHWS) to address them. Local authorities and GP consortia will have an equal responsibility to develop the strategy and to do so through the health and wellbeing board.

The JSNA will help partners to establish an evidence-based consensus on local needs and deliver intelligence to a variety of audiences, including commissioners for health and social care, elected members, local decision makers, and strategic planning processes. Through JHWSs partners will agree, at a high level, how they will address the health and wellbeing needs of their community identified in the JSNA, giving an overarching framework to underpin commissioning plans for the NHS, social care, public health and other relevant services.

The process of producing a JSNA and JHWS will be a key platform for exploring violence issues locally, and can help consolidate joint working between health, local authority, and the wider partners (eg housing, police, economic regeneration, education, voluntary sector etc).

Prevention is cost-effective

When added together, a substantial amount of NHS resources are spent on services for victims of violence – an estimated £1.2bn a year for physical injuries and £176m for mental health support from the NHS alone[32]. There is limited research in this area, but it seems likely that most of the costs are incurred responding to the physical and mental health impacts of repeat victimisation. Early identification and intervention could be a more effective use of these resources.

The cost of sexual offences

The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion, with each sexual offence estimated to cost £31,000. Much of the cost associated with sexual offences is due to lost output and costs to the criminal justice system, but the health service costs and physical and emotional costs faced by victims are estimated to cost more than £6.4billion*. Sexual assault and rape are estimated to cost an average of £22,000 and £73,000 respectively in health-related costs alone*.

* The economic and social costs of crime against individuals and households 2003/04

The most recent data on the costs and benefits of early intervention in domestic abuse cases are provided by CAADA. They estimate that the MARAC process saves public services, on average, £6,000 per case in direct costs (i.e. excluding emotional costs to victims, the costs to employers etc). The NHS receives 20% of this cost saving, with the police and the wider criminal justice system receiving 32% and 40% respectively. Without a MARAC process, the most complex cases can cost £43,000 per annum, and even the lowest risk cases that go to MARACs cost public services £4,000 per annum[33]. There is anecdotal evidence that other types of local specialist services can be equally cost-effective.

Legal obligations

The UK Government is signed up to a wide-ranging set of international commitments to ensure gender equality and other fundamental human rights. The legislation is complex but key obligations include:

- the Human Rights Act, which enshrines the European Convention on Human Rights
- Equality Act 2010
- UN Convention on the Elimination of all Forms of Discrimination Against Women
- UN Convention on the Rights of the Child
- Eu strategy for Equality between Women and Men
- UN Security Council Resolution 1325

This framework of legal rights and obligations defines violence against women as ‘gender based violence’ requiring a gender based response, and is designed to ensure that public bodies treat women differently according to their needs, rather than treating everybody the same.

[32] HM Government (2007). Cross-government Action Plan on Sexual Violence or abuse. Available at www.homeoffice.gov.uk/documents/sexual-violence-action-plan.html

[33] Coordinated Action Against Domestic Abuse. Domestic Abuse. (2010). Saving Lives Saving Money.

Safeguarding children and vulnerable adults

Under the Children Act 2004, the statutory guidance Working Together to Safeguard Children, 2010 sets out processes for shaping the NHS response to safeguarding children as part of the Local Safeguarding Children's Board's multi-agency arrangements. The independent Taskforce on Violence Against Women and Children recommended that there may be merit in using or linking to that infrastructure in developing a response to the wider agenda of violence against women and children. There is strong evidence of the close link between the violence and abuse suffered by adult women and the risks posed to their children as a result – and of the long-lasting and sometimes devastating impact on children of witnessing violence, as well as evidence on the long term impact of sexual abuse during childhood.

Legal position on safeguarding children

Under the Children Act 1989 (s17) every local authority has a duty to safeguard and promote the welfare of children within their area. The local authority must provide services to ensure that local children are able to achieve a reasonable standard of health or development; and to ensure that individual children's health or development is not significantly impaired, or further impaired.

The Children Act 2004 extends this duty to safeguard and promote children's welfare to the local authority's partners, including health, the police, probation and youth offending, and education services, by requiring them to co-operate to improve local children's well-being (s10). Furthermore, the Children Act 2004 requires these individual local authority partner agencies to make arrangements for ensuring that the need to safeguard and promote the welfare of children is embedded within the daily functioning of their service (s11). This includes both services which are provided and those that are commissioned.

Similarly, the structures and processes in place for vulnerable adults also appear to offer a useful basis for further work. Any future review of the definition of 'vulnerable adults' could present an opportunity to explore whether victims of violence and abuse could be included. Whichever approach local areas take to co-ordinate services more effectively, it is important that the distinct needs of women and children are recognised and met, and to do so many areas now have safeguarding leads with responsibilities for safeguarding vulnerable adults.

Safeguarding Adults Boards exist in many parts of the country, but they are not mandatory and their effectiveness is variable. The Government is considering in the context of the Law Commission work on social care law, whether to introduce legislation to put Safeguarding Adults Boards on a statutory footing, and also to introduce an enhanced duty of cooperation.

4. Measuring effectiveness

Liberating the NHS: Legislative framework and next steps makes it clear that the new NHS Commissioning Board will have a strong focus on patient reported outcome measures (PROMs) as well as wider patient experience and progress in reducing inequalities. This will be reflected in the Commissioning Outcomes Framework, which the NHS Commissioning Board will develop with support from NICE.

Some services for women and children who have experienced violence may well be commissioned by Public Health England once it has been set up (currently out for consultation) , and if so this will be reflected in the Public Health Outcomes Framework.

In the meantime, this section sets out:

- what we mean by commissioning for outcomes
- what we mean by social return on investment
- the sort of outcome and output measures health commissioners can use in the context of services for women and children who are victims of violence or abuse
- how these measures can be applied to mainstream and specialist services
- defining (and so measuring) different types of violence or abuse

Commissioning for outcomes

Outcome measures allow commissioners to monitor the effectiveness of services better, and should help them to answer questions such as:

- Which services best promote physical and psychological recovery for different groups of victims, bearing in mind age, disability, ethnicity, sexual orientation, gender identity, religion or belief, socio-economic factors?
- Which interventions are most likely to prevent re-victimisation?
- Where providers are buying training for staff, is this cost-effective? In particular, what training is most effective in helping front-line staff (especially GPs, midwives, health visitors and nurses) to identify, manage and refer victims of violence against women and children appropriately and in a way that maximises take-up?
- What information, systems and practices are most effective in helping front-line staff to treat victims of violence against women and children?

In summary, outcome measures should help to measure whether the service is providing quality, value for money and productivity.

Outcome measures alone are not sufficient, commissioners will need to monitor some other measures of performance (or ‘outputs’) as well as outcomes. For instance:

- Levels of user engagement
- Numbers of people using the service

Commissioners also need to measure the effectiveness of organisational structures and processes such as:

- Whether governance arrangements and leadership best promote effective service responses to victims.
- Is regional commissioning more effective for some of these services?

All of these measures would ideally be broken down further, to identify the specific needs of different groups.

Social return on investment (SROI)

Social return on investment (SROI) takes the measurement of outcomes one step further. It is a technique that allows commissioners to calculate the overall social benefit of investment in a service. This is particularly powerful for issues, such as violence against women and children, where investment by the NHS may lead to savings by the police or social services, rather than the NHS itself. There has been relatively little research on the social return on investment of services for victims of violence, but there is some early evidence that they are highly cost-effective, particularly where the wider social return is calculated.

Social return on investment (SROI) pilot

The Women's Resource Centre (www.wrc.org.uk) are piloting a two year project (April 2009 to February 2011) specifically researching the Social Return on Investment for women's organisations, including specialist providers of services for women who have experienced sexual and domestic violence.

By translating the value of the social, economic and environmental outcomes for an organisation's stakeholders into monetised form, SROI presents a fuller picture of the financial and other benefits that flow from investments of time, money and other resources. Ultimately, SROI can quantify the social value generated for each pound invested, for example, a ratio of 3:1 indicates that an investment of £1 in a organisation delivers £3 in social value.

For further information on SROI techniques, see www.sroi-uk.org.

Example outcome and output measures

Women told us[34] that they valued services that take a proactive role in identifying, responding to and preventing violence against women, given the number of women who already use or try to access health services, in comparison, for example, with the criminal justice system. Women noted that, whilst it has traditionally been considered the duty of the police and courts to respond to domestic and sexual violence, relatively few women report violence to the criminal justice system. Women therefore said they wanted health services and professionals to also have a duty to identify and respond to violence against women and girls, and felt it was more

[34] Evidence from focus groups run by the Women's National Coalition. (2009). Available at www.dh.gov.uk/vawg

appropriate for health professionals to receive mandatory training to meet their needs effectively than it was for criminal justice professionals.

A quick way of identifying women who are experiencing violence or abuse is to use a questionnaire such as the HARK questionnaire. This has four questions, designed for use in primary care and is available on many general practice IT systems. It asks women whether in the last year they have been:

- Humiliated
- Afraid
- Raped
- Kicked[35]

However, concerns have been raised[36] that this questionnaire can alienate patients and inhibit them from disclosing. A modified HARK questionnaire is used by the IRIS project that includes a safety question, such as 'is it safe for you to go home?' when enquiring about domestic violence and abuse (see Annex C for further details on the IRIS project).

Based upon what women have told us, together with an experienced service provider, we have developed some suggested outcome measures for women (see box below). These are patient-reported outcome measures (PROMs) and are designed to be applicable to all types of services for women. The full form, plus detailed SLAs, service specifications, care pathways etc are available at www.pcc.nhs.uk/violence. Services should be sensitive in how they use PROMs, as women can find it difficult to be reminded how they felt when they started using the service. PROMS should be used with women and children with different backgrounds and circumstances, to measure how effective services are for all potential users and to indicate where adaptation may be necessary to improve them for those who may have difficulty in accessing and benefiting from them.

[35] Details of HARK questionnaire can be found at http://www.library.nhs.uk/mentalhealth/ViewResource.aspx?resID=79085

[36] A Howell, NIA Project/IRIS project (personal communication)

Patient Reported Outcomes (PROMs) for violence against women services
These are designed to track individual progress as well as assess the effectiveness of services. They are based on the Supporting People and Every Child Matters high-level outcomes.

The questions are answered using the Likert scale:
Not applicable, Strongly disagree, Disagree, Not sure, Agree, Strongly agree

Being healthy:
- I am aware of my health and well-being
- I am informed about accessing health services e.g. sexual health and maternity services
- I am emotionally well
- I visit my GP less about my experiences of violence and/or abuse

Staying safe:
- I am confident about personal safety
- I feel safe at home.
- I recognise abusive behaviour from others e.g. violence, control
- I am free of abuse/violence but may need support now and then

Enjoying and achieving:
- I have control over the choices I make in my life
- I am assertive and confident
- I am engaging in education, training or employment
- I can deal with significant life changes and challenges

Making a positive contribution:
- I feel able to challenge harassment, bullying and discrimination
- I am aware of my rights and the rights of others
- I am able to challenge unjust decisions effectively
- My opinions are taken seriously by agencies and professionals

Achieving economic wellbeing
- I am now aware of any benefits I may be entitled to
- I can manage my finances
- I feel confident in dealing with authorities e.g. housing, benefit departments
- I am able to live independently with access to support when I need it

The legal system
- I feel supported and informed in my contact with the police
- I feel supported in the contact I have with criminal /civil and / or family courts
- I have enough information about the criminal justice system
- I have enough information about civil and family proceedings

Patient Reported Outcomes (PROMs) for violence against women services (continued)

Violence against women services

- It is important to me that the service provided ' women only' space
- I have been given information about other women's support services should I need it
- It is important to me that the service respected my confidentiality
- I would recommend the service to someone who has experienced violence

The full tool can be found at http://www.sericc.org.uk/policies.htm.

The majority of services collate outcomes that include reduction in risk and ensuring that the service user is safe; independent living; improvements in mental health and wellbeing and whether the service met their specific needs. Organisations collect statistical data regarding service user satisfaction and successful take up of service.

Applying these measures to mainstream and specialist services

Mainstream services

There are general wellbeing tools that can be used by mainstream services to assess whether service users who are victims of violence or abuse have improved in terms of their confidence and self-esteem (see box below for an example). Commissioners may wish to measure more specific outcomes – for example, whether women using a counselling service reduce their use of anti-depressants, or their attendances at A&E.

Warwick-Edinburgh Mental Health Well Being Scale

All outcomes measure whether service users have improved in both confidence and self esteem. One of the ways of measuring this is through the Warwick-Edinburgh Mental Health Well Being Scale (WEMWBS). The scale works on score system of / None of the time/ Rarely/ Some of the Time /Often / All of the time. (WEMWBS available at http://www.healthscotland.com/documents/1467.aspx).

I've been feeling optimistic about the future	1 2 3 4 5
I've been feeling useful	1 2 3 4 5
I've been feeling relaxed	1 2 3 4 5
I've been feeling interested in other people	1 2 3 4 5
I've had energy to spare	1 2 3 4 5
I've been dealing with problems well	1 2 3 4 5
I've been thinking clearly	1 2 3 4 5
I've been feeling good about myself	1 2 3 4 5
I've been feeling close to other people	1 2 3 4 5

Specialist services

More specialist services will require more specific measures. For example, the Taskforce commissioned work to gather views from children and young people, and the following findings emerged from both consultations. When asked to consider what a good service that was supportive to children who are victims of violence might be like, the young people (aged 13-17 years) identified several characteristics:

- Staff are approachable
- They ask direct questions about what is troubling the child / young person
- They believe the child when s/he discloses.

The Department of Health has published quality criteria for all children's services, called 'You're Welcome', which apply to all types of services for children and young people[37].

Some of the 'You're Welcome' requirements for the service included:

- a safe, comfortable, non-judgemental environment that is confidential
- suitably located and discreet so it is not obvious what it is, and easily accessible
- staffed by women only who are friendly, well-trained professionals, capable of offering counselling and support to women and children
- offer counselling as well as information, and alternatives to just talking, like art or sport
- provide accommodation, resources like personal alarms and crisis money, and play facilities for children
- have flexible opening hours and be linked into the community

Outcome measures for children

Based on this evidence, age-appropriate PROMs for children using services for victims of sexual abuse and violence might be based around:

- Was the service safe, comfortable, non-judgemental environment and confidential?
- Did the service meet your needs by providing flexible opening hours and being linked into the community?
- How did the service help you? Do you think anyone else noticed the changes in you? Who? In what way?

Other measures might be based around the following outcomes:

- increased confidence of child
- improved school attendance of child
- less conflict at home
- improved relationships at home

Details of statistics in box in footnote[38]

When thinking about outcome measures for services run by small charities, the measures should be proportionate to the nature of the service being provided in order to:

- Be suitable for small organisations to measure and collect, given small charities provide many of these services

[37] You're Welcome information available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097571

[38] Cupitt, S and Ellis, J. (2003). Your Project and its Outcomes. Charities Evaluation Services and the Community Fund.

- Measure improvements that are important to the victims themselves, even if these are not tangible (eg improved confidence), as well as more concrete measures (eg reduced use of anti-depressants)
- Be appropriate questions to ask victims, given the sensitivity of the topic

Outcome measures for domestic violence services

Some outcome measures that could be used include:

- Ambulance attendances
- Employee absenteeism related to domestic violence
- Primary care attendances for alcohol use as a coping mechanism
- Prescription profiles
- Social functioning assessments

Domestic violence services running advocacy services such as refuges and floating support services often work to a quality framework for case management, data collection and outcome measurement as part of their Supporting People contracts. In addition, CAADA has piloted and will be launching in the next couple of months an 'Insights service' which will permit simple case management, data collection and outcome measurement for all domestic abuse services.

For more detailed guidance on outcome measures suitable for charities – what they are, how to create them and how to understand them – please see *Your project and its outcomes* by the Charities Evaluation Services[39]. For the principles of proportionate monitoring plus a decision support tool, see *Intelligent monitoring: an element of Financial relationships with the third sector* by the National Audit Office[40].

[39] Cupitt, S and Ellis, J. (2003). Your Project and its Outcomes. Charities Evaluation Services and the Community Fund.

[40] National Audit Office. (2009). Intelligent monitoring: An element of Financial Relationships with Thrid Sector Organisations: A decision support tool for public bodies in England. Available at www.nao.org.uk/guidance__good_practice/third_sector/intelligent_monitoring.aspx

5. Processes

Providing good services for women and children who are victims of violence or abuse requires working within the following framework:

- Health and Wellbeing Boards
- Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS)
- Involving service users
- Quality, Innovation, Productivity and Prevention (QIPP)
- Regional commissioning

Health and Wellbeing Boards (HWB)

As mentioned above, the Health and Social Care Bill includes a provision to establish Health and Wellbeing Boards from April 2013, with shadow arrangements in advance of this date. Subject to legislation, these boards will bring together the key NHS, public health, social care and children's services leaders in each local authority area to work in partnership. These will be particularly important fora for areas such as violence against women and children, which cross many organisational boundaries.

As the Health and Wellbeing Boards develop, they will become the vehicle by which local authorities and GP consortia will undertake the joint strategic needs assessment. In addition, all Health and Wellbeing Boards will have to develop a high-level 'joint health and wellbeing strategy' (JHWS), informed by the JSNA, which spans the NHS, public health and social care and children's services and could potentially consider wider health determinants such as housing or education. GP consortia, the NHS Commissioning Board and local authorities will be under a statutory obligation to have regard to both the JHWS and the JSNA when commissioning services.[41]

Health and Wellbeing Boards will provide powerful new fora for strategic thinking, not only across a local health and care system, but across the whole place and all functions of a Local Authority, providing increased opportunities for joining up services around particular issues related to violence against women.

Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategies (JHWS)

JSNAs and JHWS are statutory duties on local authorities and consortia, and represent an excellent opportunity to establish an agreed position on local overarching health and wellbeing needs between partners. Together, JSNA and JHWS should also help partners to focus on outcomes and agree joint actions and goals. Taking 'a step back' to analyse the wider perspective of wellbeing and quality of life may help partners to gain consensus on priority issues across the system - often no single agency will be able to satisfactorily invest in the

[41] For more details see para5.22-5.24 in *Liberating the NHS: Legislative framework and next steps*

wider determinants driving need and satisfaction with services alone, but common priorities and confidence in a shared evidence base can help partners focus in on key issues and make joint working more effective. Feeding quality intelligence on violence into the JSNA process is important to make sure that strategic partners all understand the problem.

Once the new structures are in place, GP Consortia will have a duty to prepare commissioning plans, including proposals for how they intend to use their commissioning budget and how they intend to improve outcomes for patients. Consortia will need to discuss these proposals with local health and wellbeing boards to ensure that they reflect JSNA as well as JHWS.

Some areas have already done a specific health needs assessment (including service mapping, identifying gaps, involving users etc) for women and children who have experienced violence or abuse, and included key outputs from this in their JSNAs. But many have not, despite the availability of data. Local commissioners will be able to commission services for women and children who are victims of violence and abuse more effectively if they include at least basic information on violence in their refreshed JSNA.

Newcastle's JSNA
Newcastle's JSNA has a comprehensive section on domestic violence and the scale of the problem both nationally and locally. Particularly useful are the ongoing costs to the local economy of domestic violence and the potential cost savings to be made by addressing the issue more effectively. It is available at www.newcastlejsna.org.uk

We suggest:

- Including violence against women and children in the JSNA and JHWS process, including identifying children at risk of violence. This might best be based upon a separate needs assessment for women and children who are victims of violence.
- Get involved in local conversations about the role intended locally for JSNA and JHWS in informing strategic commissioning. Some questions you might want to ask include:
  - how best should the JSNA add value to existing commissioning strategies or local datasets for violence against women and children?
  - how can the JSNA help organisations across the whole local system to understand the impact of violence?
  - how might the JSNA be used to forge stronger partnerships and agree key actions that could be agreed in a JHWS?
- Once available, using the tool that EHRC are working to develop an analysis of local levels of need for support, which may be of assistance to commissioners.
- Work with the Local Safeguarding Children Board to map the number of children who are experiencing violence and abuse in their area.
- Using the Violence Indicator Profiles for the English Regions (VIPER)[42] and other national data sources to benchmark local services

[42] www.preventviolence.info

- Identifying the specific needs and risks of 'seldom heard' communities eg need for translation – local specialised charities may well have this data and expertise
- Build on the work of local fora such as the Domestic Violence Forum to co-ordinate data gathering and link commissioners in to local specialised voluntary, community or social enterprise organisations
- Considering targeting services and interventions at a local and individual level to those most at risk eg within the safeguarding agenda
- Identifying any problems caused by boundary issues, and so work better with organisations that have different geographical boundaries

Within regions, and in specific localities or neighbourhoods, local commissioners and partnerships will need to refine their assessment of need to:

- Address the specific factors that will increase the risk of forms of violence that are more prevalent in some communities than others, including trafficking, female genital mutilation, forced marriages and so-called 'honour' based violence. Other diversity strands also raise the risk of certain types of violence against women and children eg age, sexual orientation, gender identity, race and ethnicity.
- Reflect the variations in the way services are provided. The *way* in which services are provided is just as important as *what* services are provided, as women and children face different barriers to accessing them. For example, women in rural areas will access services in a different way to women in urban areas.
- Fulfil the duty of public authorities to assess the impact on equalities. This process is designed to help commissioners consider issues such as
    - The access needs of disabled women and children, including the costs of providing for accessible refuge spaces or British Sign Language interpretation
    - The barriers faced by some women and children with mental health issues or with learning disabilities, and the possibility that enhanced advocacy is needed
    - Language barriers
    - The factors that might prevent women and children disclosing violence or taking up services, such as reliance on a carer or partner or control exerted by their wider family or community; and how this might be overcome
    - Suitable support for transgender women
    - Concerns around disclosure and the service environment for lesbian and bisexual women
    - The needs of girls and younger women, including, for example, those who may be involved in gang violence (see the recent report by Race on the Agenda which identifies a gap in current responses for gang-involved girls)
    - The needs of refugees and asylum-seekers

The aim is to have data that allows you to understand patterns across the population in time, place and person, and to inform commissioning of an appropriate diversity of services to meet the needs of all women in the community.

NHS Nottingham City's use of data

Although national data referred to in this document by NHS Nottingham City PCT is now somewhat out of date (2005), it is nevertheless a good example of how a PCT has mobilised to understand the scale of the problem by applying national data to their own local situation. It also covers the health impact of domestic violence and how this impacts on a local health economy, reporting levels and PCT partnership working to tackle the problem.

Details of statistics in box in footnote[43]

Data sources for JSNA

Annex D contains a table with links to useful data sources. These include:

- Home Office data – the British Crime Survey, statistical bulletins, publications, police force level data
- Criminal justice system data – the Crown Prosecution Service provides statistics on prosecution performance, Specialist Domestic Violence Courts, police force level data broken down into principal offence categories
- Office of National Statistics data – on population, ethnicity etc
- NHS data on children and maternity services

Further information may be sought at a local level from local police forces, as well as any other relevant organisations.

Patient engagement and empowerment

Health commissioners should follow existing guidance[44] and good practice on patient engagement and empowerment like the 'Engagement Cycle' which helps promote the different types of engagement for key aspects of commissioning.

Many voluntary sector and community-led initiatives have grown from their roots in violence-related work and have a strong 'survivor-led' vision and ethos. Many commissioners do not think about involving women and children who have been / are victims of violence; they are 'easy to overlook' and can be hard to engage with authority and statutory services, and often do not get involved in any aspect of commissioning or assessing services. This means that commissioners lose valuable and vital insights into how efficient their local services are, where the gaps are and which services feel safe and effective to women.

Health commissioners must take account of relevant statutory guidance on patient involvement and work with local partners, where this makes sense, to make sure they:

- Have comprehensive service user input in the whole commissioning cycle – Joint Strategic Needs Assessment (JSNA), service delivery, care pathways etc

[43] Box footnote http://www.nottinghaminsight.org.uk/insight/jsna/adults/jsna-domestic-violence.aspx

[44] Department of Health. (2009). The engagement cycle: a new way of thinking about patient and public engagement (PPE) in world class commissioning. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098658

- Ensure that all the services commissioned for victims of violence against women and children include advocacy services where appropriate. Advocacy is particularly important for these service users, as they tend to have multiple and complex needs, very low self-confidence and difficulty in finding their way to the right services.
- Use the information gathered from involving patients and from existing feedback including national surveys, complaints and Patient Advice and Liaison Services (PALS), for example, as well as information collected through engagement such as focus groups, and websites such as NHS Choices, www.patientopinion.org and ww.iwantgreatcare.org which may be a good way of reaching those whose views are seldom heard
- Prepare to comply with the new equality duty that will come into force 1 April 2011. This will create a duty on listed public bodies when carrying out their functions and on other persons when carrying out public functions. The practical effect is that listed public bodies will have to consider how their policies, programmes and service delivery will affect people with the protected characteristics. To meet the Equality Duty, public authorities must take action to tackle the most significant issues for gender equality, including equality for trans people, in their remit. The Equality and Human Rights Commission's guidance identifies violence against women and girls as a key priority, including the need to take action to increase access to support for victims/survivors. The Commission expects public authorities to make violence against women central to their (gender) equality objectives, and to ensure the involvement of women in planning and development
- From 6th April 2011, public authorities should comply with the new public sector Equality Duty[45]. This Duty covers the following eight protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities will need to show due regard to the need to advancing equality, eliminating discrimination and fostering good relations. As with the current gender duty, this means that public authorities must take action to tackle the most significant inequalities in their remit, which are likely to include violence against women and girls. When considering the relevance of their functions and policies on equality, it will be important to consider how women may be affected and to remember that women will have other protected characteristics, for example, they may be disabled or come from an ethnic minority community. Therefore as well as taking a gender-specific approach, commissioners of services should bear in mind that having due regard for advancing equality involves taking steps to meet the particular needs of people from different protected groups and any arrangements for VAWG support services should take into account their accessibility and suitability for different groups of women[46].
- Have an explicit service user involvement strategy jointly owned with local partnerships that sets out how people who are 'easy to overlook' (such as women and children who have experienced violence or abuse) will be involved
- Involve their Local Involvement Network (LINk) and overview and scrutiny committee (OSC). LINks are expected to evolve into local Healthwatch organisations in the near future.

[45] www.equalities.gov.uk
[46] Equality and Human Rights Commission. (2010). A practical guide to revising gender equality schemes.

- Understand why some people do not use services, and take action to remedy this

Patient rights and responsibilities

The NHS Constitution sets out a number of entitlements and responsibilities for patients, the public and staff, as well as the NHS values and commitments to improving services. A number of these entitlements can help people to feel more empowered in using NHS services. All NHS bodies, and private, voluntary, community or social enterprise providers supplying NHS services in England have a legal duty to have regard for the NHS Constitution, taking it into account in their actions and decisions.

Greater choice and control

The White paper, *Equity and Excellence: Liberating the NHS,* sets out the Government's vision of an NHS that puts patients and the public first – where patients, service users, carers and families have far more influence and choice in the system, and the NHS is more responsive to their needs and wishes.

The proposals assume a future in which patients have greater choice and control over care and treatment, the choice of any willing healthcare provider wherever relevant, and the choice of treatment and healthcare provider becoming the reality in the vast majority of NHS- funded services by no later than 2013/14.

Commissioners will need to take into account any guidance on choice and any willing provider issued by the Department of Health as revised, re-issued or replaced from time to time.

What women told us about how services can empower them, or the opposite

"Within health services, I had a fantastic consultant – he was really polite, I was in the waiting room and the doctor came over with my notes, he shook my hand and asked if I would like to come with him. I felt immediately he would understand about my experience. I felt like I had control over my decisions – he asked me how I felt about everything and gave me choices. I was in control."

"My receptionist asked me, after reading my notes on screen, 'why are you trying to kill yourself? There are worse things than child sexual abuse'. She was not only belittling my notes she was belittling me."

Information to support choice

Information plays an important role in helping people to take control of their own lives. By having a better understanding of what services are available and the options that are available for managing one's choices, care and health, people can make informed decisions, working in partnership with their healthcare professional.

NHS Choices provides a range of information sources covering details on conditions, treatments, real life stories from patients who have experience violence and abuse, lifestyle guidance, self-assessment tools and links to voluntary and community services. It also

provides contact details for local healthcare services, searchable by postcode, along with patient comments and ratings of services. Patient Advice and Liaison Services can also provide useful information and advice and signpost individuals to other services, such as organisations providing advocacy support.

More personalised information routes are also available. Information Prescriptions, available through NHS Choices, from the Information Prescriptions Service (www.nhs.uk/ips) or locally through health and social care professionals, can provide women with relevant, reliable and personalised information to help them regain a sense of control and independence. Information includes details on health and social care services available, and details of organisations offering advice and support such as benefits advisors, local self-help groups or victim support.

Communicating effectively

The Department of Health has developed a communications strategy on violence against women and children. This includes developing:

- Content for NHS Choices (a public-facing website), in a new section dedicated to violence against women and children. This includes a range of films covering sexual assault and abuse, child sex abuse and FGM. Further material is being considered and the section will continually evolve and expand.
- A suite of communications materials for use by the NHS to aid women and children in receiving help[47].
- Materials to raise awareness of the issue with NHS staff, as a cultural and attitudinal shift is needed amongst staff to ensure they can appropriately respond to victims[48].

As part of the Department of Health's response to the Taskforce on the Health Aspects of Violence Against Women and Children, further reports are available detailing the experiences of women and children subject to violence who access health services for support[49].

[47] Available at www.dh.gov.uk/vawc
[48] ibid
[49] ibid

NHS staff can also be victims

The NHS is the biggest employer in the country – so it is inevitable that some NHS staff will be victims of violence, either current or ongoing. The current Operating Framework (2011/12) underlines the expectation that NHS organisations will put in place organisational health and wellbeing strategies to realise the benefits set out by the Boorman Review into the staff satisfaction and the health and wellbeing of NHS staff. This has practical benefits, such as reducing sickness absence rates.

NHS County Durham and Darlington's draft domestic abuse workplace policy

In NHS County Durham and Darlington there is a draft Domestic Abuse Workplace Policy so that managers are equipped to support staff. It will be linked to the Mindful Employers Charter. Mindful Employer is a national charter available to employers demonstrating a commitment to the mental health and wellbeing of their staff. Led and supported by employers, the Mindful Employer initiative is aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff. The charter encourages organisations to take a supportive and non-judgemental approach to supporting people in work who might be experiencing mental distress as a result of problems inside or outside of work. It offers advice on a range of practical support that can be offered to individuals in these circumstances and should be used in conjunction with HR policy such as the domestic abuse policy to ensure that staff and managers are able to access the right level of support. For further information, contact: jhall7@nhs.net.

Quality and productivity

High quality, proactive services can save public money. Recent research suggests that investment in public services, coupled with the decrease in the rate of domestic violence has lead to a reduction in the cost of domestic violence. According to research, the estimated total cost of domestic violence has fallen from £22.8bn in 2001 to £15.7bn in 2008.[50]

Specialised commissioning

Some services – such as SARCs or specialist children's sexual abuse services – need to be provided across a larger area. In the case of SARCs, these are based on Police Force areas. In the case of specialist children's sexual abuse services, this may well be based on existing (though sometimes limited) NHS referral pathways and clinical networks. For example, in London commissioning these services comes under the broader Specialised Commissioning Group.

The most appropriate and accessible configurations of services for victims of violence or abuse against women and children will vary by area, and should be a matter for local decision. *Liberating the NHS: Legislative framework and next steps* states that the Department will consider the best way to keep the specialised services portfolio under regular review. During this transition period, we would strongly encourage all health commissioners to consider

[50] Walby, S. (2009). The Cost of Domestic Violence: Up-date 2009. Lancaster University.

working closely with neighbouring health commissioners (and, for SARCs, police forces) when commissioning these services. This might be through their LSP, a new or existing consortium or any other arrangements that work locally.

Some victims of violence or abuse will need highly specialised and / or long-term care . These are likely to be expensive and demand will be unpredictable at local level. It would therefore be sensible for health commissioners and other organisations to collaborate, and the natural vehicle for this would be Specialised Commissioning Groups.

Commissioning police custody health services and forensic sexual assault work
In response to the long-standing deficit in the availability of competent forensic physicians to undertake forensic and clinical care of victims of sexual assault, the Department of Health and the Home Office are working on an impact assessment of the feasibility of transferring commissioning, funding and responsibility for sexual offences examination work from the police to health services. This work is due to be completed in spring 2011.

In line with the cross-government strategy *Call to end violence and abuse against women and girls,* a commitment to see the feasibility study through was affirmed in the DH Action Plan, *Improving services for women and child victims of violence and abuse*, which set out the priorities for implementing the NHS Taskforce report, *Responding to violence against women and children- the role of the NHS.* The feasibility study was also welcomed in Baroness Stern's *Independent review into how rape complaints are handled by public authorities in England and Wales,* to which a Government response is expected in spring 2011. *Healthy lives, healthy people*, the Public Health White Paper is consulting on the role of public health services in tackling violence and abuse, including better access to good quality sexual assault referral centres whose services include forensic examination and care of victims of sexual violence.

6. Working with non-NHS organisations

Voluntary, community and social enterprise (VCSE) sector

The voluntary, community and social enterprise (VCSE) sector is diverse in size, scope, staffing and funding of organisations. It provides a broad range of services to many different client groups. However, VCSE sector organisations share common characteristics in the social, environmental or cultural objectives they pursue, their independence from government, and the reinvestment of surpluses for those objectives.

VCSE organisations are ideally placed to suggest and provide innovative solutions to some of the challenges we face in health, public health and social care.

They can use their considerable expertise in reaching those vulnerable and hard to reach groups that statutory organisations can struggle to engage with. They also have a strong role to play in helping individuals and local communities take responsibility for their own health. Specific roles include:

- Providers of public services
- Advocates and support organisations – particularly for those most excluded
- Partners in the co-design and production of services
- Involvers and engagers of local communities
- Community activity including peer networks, social activity that contributes to building strong and resilient communities and supporting the most vulnerable and chronically excluded.

VSCE organisations play a particularly strong role in sexual and domestic violence services where most local services are provided by small, specialised, voluntary, community or social enterprise organisations. Theyhave valuable expertise, insight and experience that can improve local public services, often for the most excluded people in our communities. The voluntary sector is well placed to support commissioners in developing needs assessments and commissioning guidelines.

Commissioning from VCSE sector organisations can help commissioners to meet their obligations under equality and human rights legislation, as it provides safe places not linked to the police, immigration or social services for women and children who might not otherwise receive support.

Commissioners should be aware that there is a cost and resource implication to all of these roles and that it may be appropriate to consider contributing to organisations' strategic capacity, particularly where they hold the necessary expertise and experience, through grant or

grant-in-aid. Where services are tendered through open competition, principles of fairness and equity should be considered to ensure that smaller organisations are able to compete alongside all bidders, as outlined the *Procurement guide for commissioners of NHS-funded services*[51].

As part of the proposed reforms, the Government aims to free up provision of healthcare, so that in most sectors of care, any willing provider can provide services that meet NHS standards within NHS prices, giving patients greater choice and ensuring effective competition stimulates innovation, improves quality and increases productivity. Charities, voluntary organisations and social enterprises will have greater opportunities to offer health and care services.

The Compact

The Compact is the agreement which governs relations between the Government and civil society organisations, such as charities, in England. It aims to encourage successful partnership between the Government and civil society organisations to ensure better outcomes for citizens and communities. Civil society organisations, along with citizens and communities, are at the heart of the Big Society. The Compact was re-launched in December 2010 by Nick Hurd, Minister for Civil Society and Simon Blake, Chair of Compact Voice. The renewed Compact can be found on the Cabinet Office website[52].

Care pathways and referrals outside the NHS

When the NHS signposts or refers people to non-NHS services such as Rape Crisis Centres, they should be mindful of the Government's Compact and consider how they make resources available to support those referrals and avoid overwhelming small voluntary, community and social enterprise (VCSE) organisations. This would be supported by developing care pathways in partnership with their local VCSE sector organisations. Sample care pathways for SARCs for a range of ages (0-under 13, 13-under 16, 16-under 18 and over 18) are provided at Annex C. These could be adapted for services other than SARCs.

SARC minimum elements

Joint guidance from the Department of Health and the Home Office sets out the minimum elements expected of a SARC – such as the use of Independent Sexual Violence Advisors (ISVAs) and the standards required for forensic work[53]. Whilst SARCs are statutory services, many of the supporting services may be provided by the VCSE sector, and will need to be in line with the minimum elements.

Service standards

Some organisations have developed service standards, which commissioners may find useful:

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[51] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218

[52] http://www.cabinetoffice.gov.uk/sites/default/files/resources/The%20Compact.pdf

[53] Department of Health. (2009). A resource for developing Sexual Assault Referral Centres. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570

- NICE will develop programme guidance for the police, social services and the NHS on interventions for the prevention and reduction of domestic violence, starting in November 2011. Guidance on the care of pregnant women with complex social factors was published in Autumn 2010[54]. Further details, and updates, are available on their website[55].
- Standards for Maternity Care – Report of a Working Party (RCOG 2008)[56] sets out standards to help commissioners and providers to plan and quality assure maternity services.
- National service framework for children, young people and maternity services[57] (DH & DfES, 2004) – sets standards for health and social services for children, young people and pregnant women, aiming to ensure fair, high quality and integrated health and social care, from pregnancy right through to adulthood.
- You're Welcome quality criteria: Making health services young people friendly[58] (DH, 2007) – sets out standards to help commissioners and providers of health services (including non-NHS provision) deliver young people services.
- Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused (RCPCH, 2009) – standards for paediatric forensic medical services. Women's Aid Federation of England[59] – National Service Standards for Domestic and Sexual Violence , developed in partnership with government and the specialist domestic and sexual violence sector These link to and support the National Occupational Standards (NOS)for Preventing and Tackling Domestic and Sexual Abuse and Violence developed by Skills for Justice. Women's Aid's national accredited training programme is mapped to the NOS and covers all specialist roles including IDVAs.
- Womens Aid Federation[60] – standards for domestic and sexual violence services, being piloted with the Home Office
- Co-ordinated Action Against Domestic Abuse (CAADA)[61] have an accreditation process for Independent Domestic Violence Advisors (IDVAs) and for Multi-agency Risk Assessment Conferences (MARACs)
- Respect[62] has standards in place and we would encourage commissioners of perpetrator programmes to be aware of these
- Rape Crisis England and Wales[63] have also developed their own service standards (plus a costed funding model for Rape Crisis Centres[64]

[54] http://guidance.nice.org.uk/CG/Wave14/29
[55] National Institute for Cilinical Evidence. www.nice.org.uk
[56] http://www.rcog.org.uk/womens-health/clinical-guidance/standards-maternity-care
[57] Department of Health, Department for Education and Skills. (2004). Young People and Maternity Services. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101
[58] Department of Health. (2005). You're Welcome quality criteria: Making health services young people friendly. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4121562
[59] www.womensaid.org.uk
[60] www.womensaid.org.uk
[61] www.caada.org.uk
[62] www.respect.uk.net/
[63] Available from policy@rapecrisis.org.uk
[64] Funding model produced by Economic Development and Regeneration Consultants at www.ekosgen.co.uk

7. Next steps

For health commissioners

In addition to this guidance a range of resources to support commissioning are available at www.pcc.nhs.uk/violence to:

- Identify what range of services for women and children who are victims of violence they are currently commissioning, both as a single organisation and through their Local Strategic Partnership (LSP)
- Work with service users and local specialised organisations to inform all parts of the commissioning cycle
- Use local and national data to identify local needs, and feed these in to their JSNA. Local authority and other key partners should be invited to take contribute data, sense check, and work jointly to agree an overarching consensus around local priorities.
- Start using, or increase the use of, outcome measures and social return on investment[65] techniques, to help identify effective and ineffective services, and re-commission or de-commission accordingly

For regulators

By April 2012, providers of VAWC services will be required to register with the Care Quality Commission (CQC) for the healthcare and adult social care services that they provide. In order to be registered they will need to comply with sixteen registration requirements that set the essential levels of safety and quality. Registration of providers is being phased in, starting with NHS trusts who registered with the CQC in April 2010. Since then, different providers are required to register in phased groups depending on what services they provide and how they are commissioned. The Care Quality Commission has the power to inspect registered providers and can take enforcement action directly against any provider that does not meet the essential levels of safety and quality.

Commissioners may wish to contact the CQC to clarify the status of providers and whether they are required to register prior to commissioning services.

Ofsted regulates and inspects childcare providers (including childminders) and children's social care providers (including children's homes, residential family centres, fostering agencies, voluntary adoption agencies and adoption support agencies). When they inspect a setting, they judge whether a provider is meeting the relevant regulations, which include safeguarding and protecting the welfare of children and young people. All providers are required to report child protection concerns, including allegations of abuse or violence. OFSTED has a variety of enforcement powers available, where providers are failing, or have failed, to meet the requirements of their registration. This includes taking action against those who are not adequately safeguarding children and young people.

[65] www.sroi-uk.org

Annex A – outcome measures

What are outcome measures?

An outcome measure "is a measure of change, the difference from one point in time (usually before an intervention) to another point in time (usually following an intervention)"[66].

Outcome measures look at the changes, benefits, learning or other effects that happen as a result of your activities. The outcome framework provides key measurable outcomes that demonstrate the tangible benefits being achieved by the delivery of support services.

Outcomes can occur at many levels. They may be for:

- Individual clients
- Families
- The community
- The environment
- Organisations
- Policy[67]

Why outcome measures are helpful for both commissioners and providers

An outcomes approach helps services and organisations to deliver more effectively for their client groups. In particular, it helps make services more client focused and needs led, by identifying what works well in services and what could be improved.

Managing outcomes

This involves using the information from outcome monitoring to make a service more effective. Outcome management is not limited to monitoring for accountability purposes, but is an integral part of project planning and review.

Examples of outcome measures in health and social care

- Mainstreaming Gender and Women's Mental Health Implementation Guidance www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4072067
- Department of Health Commissioning framework for health and well-being www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072605.pdf
- Improving Safety, Reducing Harm. Children, Young People and Domestic Violence. A Practical Toolkit for Frontline Practitioners www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108697

[66] Kendall, 1997
[67] With thanks to the Charities Evaluation Service, www.ces-vol.org.uk

- Commissioning a brighter future: improving access to psychological therapies - positive practice guide www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074821.pdf
- Developing the clinical and health improvement indicators for the Quality and Outcomes Framework (QOF) www.nice.org.uk/aboutnice/qof/qof.jsp
- Tackling the health and mental health effects of domestic and sexual violence or abuse www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136610
- Health of the National Outcome Scales (HoNOS) is the most widely used routien clinical outcome measure used by mental health services www.rcpsych.ac.uk/clinicalservicestandards/honos/whatishonos.aspx

Outcome measures on violence

Currently there are no standardised outcome measures for victims of violence. However there are statistical monitoring systems and management statistics in use. The majority of organisations and agencies work with a range of measures and to date this is one of least researched areas of evidence based outcome work. There are several pilots researching evidence based outcomes, which should be completed in early 2010.

The Likert Scale

The most commonly used qualitative outcome measure is based on the Likert Scale. This is an ordered, one-dimensional scale from which respondents choose one option that best aligns with their view[68].

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
I am informed about accessing health services	[ ]	[ ]	[ ]	[ ]	[ ]

'Measuring outcomes is a major conceptual and practical problem. Many different measures are currently available yet no consensus has been reached on which should be preferred over others, or about which should take priority when they conflict. It is shown that however assiduous the search, the 'perfect' outcome measure may always remain elusive'.
Reva Berman Brown, Sean McCartney and Louise Bell
http://www.springerlink.com/content/u377233880711471/

Some useful websites:

- www.ic.nhs.uk - The primary aim is to drive the use of information to improve decision making and deliver better care. They provide accessible, high quality and timely information to help frontline health and social care staff deliver better care.

[68] www.changingminds.org

Research

- www.evidence.nhs.uk – NHS Evidence allows everyone working in health and social care to access a wide range of health information to help them deliver quality patient care. Launched in April 2009
- www.npcrdc.ac.uk – the National Primary Care Research and Development Centre is a multi-disciplinary, academically independent centre, established by the Department of Health in 1995 to undertake a programme of policy related research in primary care.
- www.svri.org - The Sexual Violence Research Initiative aims to promote research on sexual violence and generate empirical data that ensures sexual violence is recognised as a priority public health problem.
- Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey Home Office Research Study 276, 2004, with Jonathan Allen, based on a consultancy to the Home Office British Crime Survey.
- The Cost of Domestic Violence, 2004, from research funded by the DTI Women and Equality Unit.
- 'Comparing the methodology of the new national surveys of violence against women', *British Journal of Criminology*, 2001, 41, 3, 502-522, with Andrew Myhill, is based on Nuffield Foundation funded work.
- http://www.preventviolence.info/ - a collection of evidence, including national and international research, links to the WHO and a link to the VIPER tool which provides data on violence for Local Authority areas.
- Primary Care Identification and Referral to Improve Safety of women experiencing domestic violence (IRIS): a randomised controlled trial in primary care

International research

- www.mwa.govt.nz/news-and-pubs/publications/pathways-part-one - As part of its work to improve women's well-being, the Ministry of Women's Affairs has led a research project on effective interventions for adult victim/survivors of sexual violence.
- www.who.int/gender/violence/multicountry/en/ - The WHO Multi-country Study on Women's Health and Domestic Violence Against Women. This landmark study, both in its scope and in how it was carried out, shows that VAW is widespread, with far-reaching health consequences.
- 'Indicators to measure violence against women' UN Expert meeting, Geneva 2007, paper: http://wwan.cn/womenwatch/daw/egm/vaw_indicators_2007/papers/Invited%20Paper%20Walby.pdf
- 'Improving the statistics on violence against women', *Statistical Journal of the United Nations Economic Commission for Europe*, 22, 4, 193-216, 2005.
- *Developing Indicators on Violence Against Women*, 2006.
- *Towards international standards for data collection and statistics on violence against women*, 2006, Member of UN Task Force on Violence Against Women, 2006-.

Service providers

- www.rapecrisis.org.uk – Rape Crisis England and Wales have produced National Service Standards
- www.womensaid.org.uk – Women's Aid Federation England have produced National Service Standards

Policy

- www.wcc.networks.nhs.uk/ - this site brings together all the information on WCC, including WCC datapacks for local areas
- http://www.homeoffice.gov.uk/crime/violence-against-women-girls/strategic-vision/ The coalition government has launched a paper outlining how they plan to tackle violence against women and girls
- www.dh.gov.uk/en?Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108697 This toolkit provides specific information about children, domestic violence and related issues; an overview of Every Child Matters and the tiers of intervention; principles of commissioning services; risk assessment and safety planning information; guidance for schools; clear explanations of key standards and policies; sample forms and key fact sheets.
- Improving Safety, Reducing harm: Children, young people and domestic violence www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108697
- http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage - At the Forced Marriage Unit, trained professionals offer confidential advice and assistance to those who have been forced into marriage, those at risk of being forced into marriage, people worried about friends or relatives and professionals working with actual or potential victims of forced marriage.
- http://www.dcsf.gov.uk/CAMHSreview/ - This review of CAMHS services is now accompanied the Government's response. It includes resources which provide practical advice for those who plan and deliver support for children and young people's emotional wellbeing and mental health.
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109705 - this cross-Government action programme aims to improve everyone's mental wellbeing, and the services that provide mental health care.

Annex B – care pathways

A collection of care pathways – for SARCs and other services – are available at www.pcc.nhs.uk/violence. If you have a care pathway you would like to share, please e-mail violence@dh.gsi.gov.uk .

Annex C – Case examples

With many thanks to the organisations who have agreed to share their work, below we provide some examples of organisations identified as providing an extremely good service to victims of violence. Whilst some, for example a Sexual Assault Referral Centre, work exclusively with victims of rape or sexual assault, others may work across several forms of violence, especially those services responding primarily to the needs of black and minority ethnic women. Below we set out the:

- Type of service provided
- Data collected – and therefore what health commissioners might expect in terms of monitoring and outcomes information
- How the data is used – by the service, and also the potential for use by commissioners.

More detail – including datasets, SLAs and service specifications – for these services is available at www.pcc.nhs.uk/violence.

Domestic violence

Solace Women's Aid (SWA)[69] provides accommodation and community-based services to women and children who have experienced domestic and sexual violence. Their visions and values underpin an empowering approach to working with service users to enable them to live safely and independently. Their services are modelled on a three stage approach with some services bridging the different stages.

- Safety – immediate support services including advice and outreach; advocacy and legal services; child protection and vulnerable adult work.
- Recovery – ongoing support through refuge and floating support services; advice and outreach casework; legal casework; specialised work targeted at specific communities and access to refuge services.
- Independence – holistic support including counselling for women and children; parallel support and family support; parenting and health services; domestic violence group work and life skills.

Access to refuge project – supporting women who misuse drugs and alcohol
This service provides specific support to women and children who have experienced substance misuse, enabling women to access and sustain emergency refuge accommodation and to resettle successfully into the community. The service also provides therapeutic support to children who have experienced problematic substance misuse in their family. This service bridges the recovery and independence stages of their model.

Monitoring and evaluation is targeted at both children and adults. Effectiveness is evaluated by:

[69] www.solacewomensaid.org

Working closely with service users to identify improvements in service delivery through a distance travelled measurement tool – the Outcomes Star (domestic violence version)[70] to track the distance travelled and therefore the impact of services on individual service users. The tool used for the therapeutic children's service is the Strengths and Difficulties Questionnaire (SDQ)[71]. Data is collated and used to target interventions and improve service delivery.

  - Annual service user satisfaction survey
  - Annual service user focus groups across services
  - Exit questionnaires
  - Individual feedback through key worker and service user plan
  - Service user sub-group of the Board of Trustees

- **Quality management** using the European Foundation for Quality Management (EFQM)[72] business excellence model:
  - Setting challenging internal key performance indicators with reporting to service users, the Board and key partners. These include contract compliance and ensure continuous improvement. Solace use national standards sets including Drugs and Alcohol National Occupational Standards (DANOS)[73].
- **Internal systems**:
  - Case file audits
  - Case conferences
  - Multi disciplinary team working protocols eg team around the child
  - Reflective practice embedded into all staff and team management systems, including clinical and staff supervision and appraisal processes
  - Training programme for staff integrates best practice
- **Organisational Planning**: all available information is used to inform the annual organisational plan. The agreed plan is used as a framework from which team and individual work plans are set and monitored. These plans are reviewed quarterly to map progress and bi-annual reports produced for the Board. The Board holds an annual review and planning day.
- **Partnership working**:
  - Annual stakeholder questionnaires
  - Membership of local area domestic violence strategic groups to ensure effective partnership working to meet the targets set for the co-ordinated community response to domestic violence.

SWA uses a casework database. Data collection includes:

- demographic information for service users, staff and Board
- referral details, including borough (or area) of origin
- history of services accessed, interventions used and progress made

[70] www.outcomesstar.org.uk
[71] www.sdqinfo.com/b1.html
[72] ww1.efqm.org/en
[73] http://www.alcohol-drugs.co.uk/DANOS/DANOS.html

- service users self assessment information including prioritisation of need, and their starting point on the outcomes star and subsequent distance travelled
- safeguarding information
- complaints and serious incidents
- organisational and individual assessment of risk
- accidents and health and safety information
- staffing information including Criminal Records Board status, continuing professional development, exit information, absence monitoring, staff satisfaction collected via survey monkey, staff turnover
- benchmarking against other providers in terms of quality and cost
- specific data to inform national and local planning.

For further information on the database contact info@solacewomensaid.org.

Data collected from service users informs service planning and enables targeting of interventions and continuous development of the service. It ensures service users have a real influence on service planning both at an individual and service level. It also enables service users to track their own progress and therefore increase levels of independence. Staff are able to track service users' progress and identify their skills deficits and strengths to enable continuous improvement. Organisationally, Solace are able to measure progress, drive quality, enable good governance, identify trends and unmet needs and plan service delivery. Benchmarking against external agencies allows Solace to check that their services remain at the forefront of best practice. Robust measurement of outcomes and outputs enables Solace to demonstrate both contract compliance and added value to funders. Solace receives a very small amount of its funding (less than 0.1%) from the NHS.

Independent Domestic Violence Advisor (IDVA) service

WORTH (Ways of Responding through Health)[74] is a fully integrated and coordinated Independent Domestic Violence Advisor Service across West Sussex. Available 24 hours a day, seven days a week, 365 days a year, WORTH serves a population of 780,000 identifying, assessing and assisting victims of domestic and sexual violence.

Simple, immediate access is available to anyone over 16 suffering from current domestic abuse or the effects of historic abuse. Victims attending hospital are seen immediately and Independent Domestic Violence Advisors (IDVAs) attend primary care locations within one hour. Teams of IDVAs are integrated within the Emergency Departments of the Hospitals, and Witness Care Units of Sussex Police. Independent Sexual Violence Advisors (ISVAs) are integrated within the Sexual Assault Referral Centre (SATURN Centre).

This core service is delivered by West Sussex County Council (WSCC) and jointly funded by WSCC and West Sussex Primary Care Trust. CAADA Leading Lights Accreditation[75] was gained in 2008.

[74] www.worthservices.org

[75] CAADA's Leading Lights accreditation programme is designed to recognize and reward safe practice in IDVA services across England and Wales, for more info see www.caada.org.uk/qualityassurance_accreditation/leading_lights_accreditation.htm

- **Identification** – active identification of victims by health professionals is essential and WORTH has a full time post dedicated to training, coaching and mentoring health staff to enable them to ask about domestic violence and to handle a disclosure.
- **Assessment** – all clients are risk assessed (using DASH Risk Indicator Checklist) at each contact and the level of risk is regularly monitored. Case management takes place every six weeks and cases are only closed when the risk has reduced and the reduction has been sustained. Clients are then followed up six months after client closure and their safety and well being are reassessed.
- **Assistance and support** – full IDVA services, therapeutic services for victims (and their children) are provided plus full care pathways to other relevant support agencies and immediate access to safe accommodation. On-site legal clinic and emotional support services are provided by qualified counsellors.

Effectiveness is monitored through the reduction of risk and the outcomes for clients. It is paramount that each client is treated as an individual with individual needs. This is assessed through the following:

- WORTH is part of the first national multi site evaluation of IDVA Services (Safety in Numbers) and now through external evaluation reports produced by Co-ordinated Action Against Domestic Abuse (CAADA).
- Monthly management meetings monitor information within a culture of continuous improvement.

Data is collected through the Modus web-based case management system and extensive reporting facilities are available. For example, anonymised data is exported quarterly and further analysis is carried out by Community Safety Partnership (CSP) analysts and reports provided to CSP partners. The use of a web-based system allows total flexibility enabling IDVAs to work effectively from any location. IDVAs and management have immediate access to reports which enable them to monitor and improve service. Data is instantly available to send to CAADA for the evaluation of outcomes and effectiveness. All partners have regular comprehensive information, which has facilitated the service being funded by West Sussex County Council and West Sussex PCT on a sustainable basis. The WORTH team and management have instant access to extensive reports covering all aspects of the service. For more information on the IT that supports this data collection, please contact Trish.harrison@worthservices.org.

Sexual violence against women

South Essex Rape and Incest Crisis Centre (SERICC)[76] provides a service to women and girls who have been raped, sexually assaulted, experienced childhood sexual abuse, sexual harassment or who have experienced any form of sexual violence at any time in their lives. This includes telephone support, counselling, support groups, outreach, education and training.

[76] www.sericc.org.uk

SERICC collects and collates anonymous statistical data as way of evaluating its service delivery. In addition, information is collected directly from service users every six weeks. It covers their progress on a number of areas:

- mental and physical health (for example, whether they stopped or reduced prescribed medication, lessening of depression, improved self-esteem)
- personal and social development (for example, whether they are more able to enjoy recreational activities, more able to understand or cope with intimate relationships)
- access to and use of services and information (for example, whether the service has helped improve their access to housing, provided support in their contact with the criminal justice system); and whether they are getting their planned programmes of support.

At the end of their time with the service, users fill out a questionnaire about the same areas and an outcome sheet is provided to them. A six weekly service user group is facilitated by SERICC and there is representation on SERICC's management team. For example, individual service users are asked the following questions:

- are the service users making progress
- are they making expected progress in line with the care/support plan
- is progress consistent
- is there a relationship between the progress made and the level of support provided
- is further intervention required?

Service user outcomes include questions based on:

- health and well being
- personal safety
- independent living
- family, social, community and personal relationships.

SERICC collects and collates anonymous statistical data, this includes:

- demographic information – age, ethnicity, employment, first part post code, disability, children etc
- referral details; type of abuse and effects
- case workers – eg case loads etc
- activities – amount of sessions, contacts, did not attend (DNA's)
- criminal justice engagement eg police, courts, forensic etc
- repeat victimisation
- outcomes
- reviewing progress
- continuous improvement, professional development and training.

Information on the purpose built database can be obtained from Lee@sericc.co.uk

Analysis of collected data enables:

- continuous monitoring of numbers of service users and their needs
- monitoring of the progress of individual service users

Information from the dataset has been used by the service and commissioners to identify an increase in referrals and waiting lists, therefore allowing commissioners to provide further funding to reduce waiting lists. It has also helped identify a need for advocacy services for women who have experienced sexual violence, convincing commissioners to provide funding for an advocacy post. SERICC receives 25% of its funding from the NHS.

Identification and referral

IRIS – Identification and Referral to Improve Safety, is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. The target patient population is women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

IRIS is a collaboration between primary care and third sector organisations specialising in DVA. An advocate educator is linked to general practices and based in a local specialist DVA service. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices

The IRIS service

- Training and support: the practice team receives in-house training and ongoing support. Clinician training focuses on identification of DVA through clinical enquiry and appropriate response, referral and recording. Training for reception and administration teams focuses on understanding DVA, data handling, confidentiality and safety.
- Electronic prompt: This appears in the patient medical record in the form of a pop-up template called HARKS. HARKS is a mnemonic for Humiliate, Afraid, Rape, Kick and Safety and is triggered by Read-coded symptoms and conditions associated with DVA. HARKS is reminder to ask and record data about DVA.
- Practice champion: at each practice a lead professional is identified to be the main point of contact for the advocate educator and receives a further session of training to enable them to be the practice DVA lead.
- Health education resources: posters about DVA are put up in practices and cards provided for patients. Practices receive referral forms and care pathways for female survivors, male victims and perpetrators.
- Named contact for patient referrals - practice staff can refer directly by phone, fax or email to the advocate educator.
- Advocacy for patients – the advocate educator provides patients with emotional and practical support and carries out risk assessments and safety plans. The advocate educator acts as a triage and brokering service, signposting patients into other services as necessary.

IRIS data

- Practice level (half-yearly): new identifications of women experiencing DVA, breakdown of types of abuse, and record of referral and safety discussion
- Specialist DV agency level (half-yearly): number of referrals received, number of women receiving advocacy, demographic information on women receiving advocacy (age, ethnicity, sexuality, number of children), self-defined co-morbidity (mental health problems, substance use, disability), advocacy case profiles (immigration status, pregnancy, history of abuse, perpetrator), advocacy case outcomes (frequency of contact and type of support), service-user outcomes.

Use of data

- Monitoring of individual practice performance on identification and referral; basis for feedback to that practice by the advocate educator and identification of additional training needs
- Monitoring of impact of education and support programme
- Monitoring of quality and scope of the advocacy provided by the specialist agency

For further information please contact Annie Howell at ahowell@niaproject.plus.com or Medina Johnson at medina.johnson@nextlinkhousing.co.uk.

Sexual Assault Referral Centre (SARC) – St. Mary's

St. Mary's SARC[77] provides a comprehensive and co-ordinated response to child and adult victims of sexual violence. This includes:

- crisis support
- forensic medical examination
- therapeutic medical services (ie HIV /HEP B PEP; emergency contraception)
- ISVA support (including child advocacy and young persons ISVA)
- counselling
- 24 hour telephone support and information line
- consultancy and training.

St. Mary's SARC monitors its service through:

- participating in, and conducting, research and audit studies using victim experience and service user feedback from the police and Crown Prosecution Service.
- Case tracking to monitor the level and type of service used, the outcomes and referral to other agencies. In respect of counselling clients, a Hospital Anxiety and Depression (HADs) score is conducted at initial and final sessions.
- Reviewing and exploring Did Not Attend rates.
- Using dip sampling of cases and case discussion to establish quality of service provided and any learning as part of team meetings and peer review.

[77] www.stmaryscentre.org

- A quarterly dip sampling of notes, which are then measured against elements of service and joint agency response and fed back to organisations and individuals where appropriate.

St. Mary's SARC collects the following data (case dependant) allocating each case a unique identifying number:

- Demographic – name; age; gender; ethnicity; employment; housing status; disability;
- Family status – children; carer / person with parental responsibility in appropriate cases; parents (birth/ adoptive); siblings
- Social services links – social worker details; ? known to social services (including children's' social services); subject to care proceedings
- Assault details: date and time of attendance; type of assault; perpetrator details if known;
- Police / CPS – police officer attending details; investigating officer detail; date and time of report; police division; self/police referral; FWIN number
- A range of details pertaining to the examination
- Support needs – ISVA support details; support needs assessment; referral to other agencies; details pertaining to counselling (initial session; attended etc)
- Case details – case outcomes including CPS decision; CICA information.

The data system has been specially designed for St. Mary's SARC (and is being used by other SARCs). Further information can be obtained from Bernie.Ryan@cmft.nhs.uk.

The data collection:

- informs services demand and capacity and current skill mix
- is utilised for funding bids to evidence services provided
- informs training and development
- informs annual reports and reports to inform other services
- informs commissioning and service development.

St Mary's receives 10% of its funding from its PCT, with substantial help from their acute trust on running costs.

Training Forensic Physicians

Some SARCs have a system whereby the Forensic Physicians are encouraged to gain postgraduate qualifications, for example Membership of the Faculty of Forensic and Legal Medicine (MFFLM) and Diploma in Forensic and Clinical Aspects of Sexual Assault (DFCASA). Those that achieve this may then get enhanced payment to reflect their competence. Attainment of these qualifications is useful in providing the Forensic Physician with evidence to demonstrate their skills to employers and external bodies, such as the police, crown prosecutors and courts. This in turn has been shown to enhance the confidence of the doctor and results in improved staff retention and superior quality of service. The enhanced payment also reflects the potential seniority of the clinician and is offset by them then acting as a resource for more junior staff in terms of teaching and mentoring etc.

Sexual Assault Referral Centre (SARC) – The Treetops Centre

The Hampshire and Isle of Wight SARC (The Treetops Centre)[78] provides a comprehensive service to people who have experienced rape or sexual abuse. The Clinical Director and Forensic Physicians are female and have a clinical governance agreement with the PCT. The Centre has received awards from the Strategic Health Authority and Hampshire Constabulary for its partnership approach. It is co-located with a pre-existing domestic violence service, and support and advocacy workers from that service also provide a service to the SARC. The Centre:

- ensures the best possible care of the client to minimise the risk of further harm, physical and mental health issues and to promote recovery;
- facilitates forensic examination so that evidence can be collected for use in the investigation of crime should the client choose to do so;
- promotes partnership working at all levels throughout Hampshire and the Isle of Wight and nationally to assist with providing best practice and best value;
- provides a centre of excellence which places client care and quality of service at the heart of its work.

The Treetops Centre collects and collates anonymous statistical data as a way of evaluating service delivery. There are currently five Key Performance Indicators for the Centre. These are monitored monthly by the PCT Provider and Commissioners. These are:

- **Infection Control** – evidence regarding forensic cleaning of SARC medical room, split into three sub-sections: forensic Medical Room forensically cleaned and sealed after each client; deep clean of forensic medical room undertaken each month; decontamination check / swabs sent to Forensic Science Service every six months.
- **Service User Experience** – information is collected directly from service users by way of Client Satisfaction Cards. Each client receives an Information Pack relevant to the geographical area in which they live and boxes are available at the Centre for clients to leave completed cards. The cards are also able to be returned via a prepaid service, allowing return by post anonymously.
- **Improving Productivity** – statements requested by police from Forensic Physicians / Early Intervention Project workers will be completed within ten days.
- **Care Management** – if a client requests a follow up phone call, it is made within 72 hours of attendance to the Centre. This will be undertaken by the Early Intervention Project ISVA or the SARC Young Persons Worker. When the follow up call is undertaken, the worker will complete a short client feedback form. Agreement is being sought from the SARC Board to seek consent from clients that they can be contacted six months and one year after the initial attendance to identify outcomes. This will evaluate the outcome of their experience over a period of time. Outcome measures are currently being agreed. Currently information is captured on services that clients are signposted to. The evaluation could give an indication of the attendance by clients of these services.

[78] www.treetopscentre.co.uk

- **Access** – for all clients requiring a forensic medical examination, the Forensic Physician will be available at the centre within one hour of being called.

The Centre collects a range of date including: demographic information:

- Demographic – gender, age, PCT area, Rape Crisis area, Police Operational Command Unit area, ethnicity, disabilities, etc
- Referral details; type of abuse and effects
- Case workers – eg caseloads etc
- Activities – amount of sessions, contacts, DNA's
- Criminal justice engagement eg police, courts, forensic etc
- Repeat victimisation, outcomes, reviewing progress
- Continuous improvement, professional development and training.

A bespoke database was commissioned from IG Group. This database has now been replicated in other SARCs. Information on the purpose built database can be obtained from mary.bridgman@ports.nhs.uk.

Analysis of data collected benefits the Centre through:

- Continuous monitoring of numbers of service users and their needs.
- Enabling monitoring of the progress of individual service users.
- Information from the dataset is used by the service to identify an increase in referrals and trends, therefore allowing the SARC Board to set objectives and identify priorities e.g. Hampshire and Isle of Wight wide rape prevention campaign, DVD Rape: Short Word, Long Sentence and internet campaign – Seal the Deal.
- Information from the dataset helped identify a need for Independent Sexual Violence Advisers (ISVAs) across Hampshire and the Isle of Wight.

The Centre receives 50% of its funding from the NHS.

Harmful practices

Southall Black Sisters (SBS)[79] manage a resource centre in West London that provides a comprehensive service to black and minority ethnic women experiencing violence or abuse, particularly domestic violence and harmful practices. SBS offer specialised telephone and face-to-face advice, information, casework, advocacy, counselling and self-help support services in several community languages.

SBS monitors:

- the number and type of enquiries and cases
- case outcomes and equality measures
- number and type of support groups activities and counselling services, and their outcomes and equality measures.

Service users, agencies, staff and volunteers are also asked to complete evaluation forms every three to six months. These focus on a satisfaction survey and an outcomes survey,

[79] www.southallblacksisters.org.uk

which includes questions on whether or not they or their client show any improvements as a result of the SBS intervention in their health and wellbeing; independent living; reduced levels of depression, suicide and self-harm, reduced repeat victimisation; and if they have achieved other successful outcomes in terms of actions to resolve their problems and improve safety, eg reporting abuse, obtaining convictions, obtaining indefinite leave to remain in the UK etc. These may be short-term/immediate, intermediate or long-term outcomes. Service users are also asked for their views at members /focus/support group meetings and have representation on the Management Committee. There is an evaluation every three to six months of the data, which is presented in an anonymous form to funders, Management Committee or internal assessments and reviews.

SBS collects the following data:

- the abuse experienced and its effects, and risk assessment
- impact on and risks to children and others, eg siblings
- information on perpetrator/s
- inter-relation with other issues, eg immigration, destitution, suicide and self-harm
- causes of the abuse eg notions of honour
- equality and demographic factors
- action taken by SBS and other agencies
- outcomes
- repeat victimisation
- on-going work and links with other services, eg support group activities and counselling etc
- staff work load, file management, advice and actions.

A manual system is being transferred to a computer based case management system, and so the data is subject to some changes. (The new computer cases system is similar to that of SERICC, contact Lee@sericc.co.uk for further information).

The data benefits SBS by:

- enabling assessment of whether or not the interventions or service provision is appropriate and effective in addressing need, and allowing for adjustments if there are any problems
- ensuring staff workloads, advice and actions are appropriate, and identify training and development needs
- providing information for funding bodies to ensure targets and outcomes are met
- helping to inform policy, educational, developmental and research work as an evidence base
- helping to identify new needs, trends and patterns to influence commissioning and other priorities.

SBS receives none of its funding from the NHS.

Female Genital Mutilation (FGM)

The African Well Woman's Clinic (AWWC) was set up in 1997 to find ways of promoting a better service to women and children who have experienced FGM. The clinic is an example of

how services have been developed to meet the needs of immigrants and vulnerable people in the society. The clinic provides access, advice, information, counselling and surgical reversal. The clinic reaches out to the community, educates and empowers those at risk.

Overall monitoring and evaluation is done by the host trust (Guy's and St Thomas's Hospital), however, the clinic collects data and audit its service using word of mouth and questionnaires from clients about the service. The service also works closely with the police and the Home Office.

AWWC collects demographic information, such as age, country of origin and birth. The service sees about 400 cases every year, with clients from all over the UK. The service includes:

- Counselling
- De-infibulation clinics.
- Professional training – in-house, locally, nationally and at international levels
- Research / audit, professional development

For further information, please contact comfort.momoh@gstt.nhs.uk.

Trafficking

The POPPY Project[80] was set up in 2003. It is funded by the Office for Criminal Justice Reform (reporting to the Ministry of Justice) to provide accommodation and support to women who have been trafficked into prostitution. It has 54 bed spaces in houses nationally. The POPPY Outreach Service works to improve the safety and wellbeing of women from all over the UK who have been trafficked and who are in need of short-term support and advocacy.

Data collection includes:

- demographic information (age or age-disputed, ethnicity, pregnant/nursing etc)
- referral details, including borough or county where she was identified
- whether or not she is in prison / detention / police custody
- her current National Referral Mechanism status
- her current immigration / asylum status
- a brief outline of current needs.

Data is entered into an access database. For further information contact Abigail.stepnitz@eaveshousing.co.uk

[80] www.eaves4women.co.uk/POPPY_Project/POPPY_Project.php

No recourse to public funds
For one group of victims of violence there is an additional barrier to accessing any form of support. These are people who are subject to immigration control and so have no recourse to public funds. This means that they cannot get welfare benefits and in most cases any form of social housing. However, in some cases, social services may have a duty to provide services (including accommodation) under community care or human rights legislation, but without informed advocacy women find this support very difficult to access.

A Home Office pilot project for victims of domestic violence with no recourse to public funds commenced in November 2009 and was scheduled to run to the end of August 2010. On 16th July, the Home Secretary announced an extension to the pilot until the end of March 2011 and a commitment to find a long-term funding solution to the issue.

Eaves Housing for Women Limited are acting as the national coordinating body to identify and manage refuge provision for victims during the pilot. Refuge providers supporting the victims are provided with 20 working days of funding to cover essential housing and living costs incurred in supporting the victim whilst they complete an application for Indefinite Leave to Remain (ILR) under the Domestic Violence Rule. Once an application is submitted to UKBA, the refuge will be provided with further funding for a maximum of 20 working days while UKBA come to a decision on their application. Underpinning this pilot is a commitment by UKBA to decide ILR applications within 20 working days of receipt, provided that all the required supporting information has been included with the application. The pilot is monitored on a monthly basis, and a full evaluation will take place following completion.

NSPCC Brighton Grove Therapeutic Service

The NSPCC Brighton Grove Team offers a therapeutic service to children and young people who have experienced abuse, neglect, domestic violence or other forms of harm. The service provides a safe, supportive and confidential environment where children can work through issues that are troubling them. The service aims to help young people:

- Express their feelings
- Make sense of their experiences
- Feel safe and secure in their relationships
- with adults
- Feel better about themselves

The service typically works with children and young people aged 4-18 years. They may be living with their parents, relatives, foster carers, adoptive parents or in residential care. It works with young men and women, gay or straight, of different races, cultures and abilities, and tries to make sure that Brighton Grove is safe and welcoming for everyone. Children can be helped to explore their experiences and express their feelings through play, art, talking or focussed activities. Sessions with a worker are usually held on a weekly basis at Brighton Grove.

Children who have experienced abuse or neglect can benefit from focussed work with their carer to help them develop a trusting, safe relationship. Carers are supported in doing play activities at Brighton Grove and at home with their child, to strengthen their relationship and help their child feel safe and secure.

The service offers child-focused support to parents and carers of children who have experienced abuse or neglect, to help them think about the effects of children's experiences and make sense of their sometimes confusing and challenging behaviours. They support carers in helping children with their feelings and behaviour. We also help carers to take care of themselves. The service offers consultation on the impact of trauma; attachment; children's emotional and behavioural needs. This can help with planning for a child or undertaking a specific piece of work, on a one-off or on-going basis. Training is delivered to multi-agency staff on attachment; assessing attachment; and the impact of trauma. Group work is delivered to carers on attachment and a therapeutic approach to parenting.

Effectiveness is evaluated through the use of the Trauma Symptom checklist for Children and Young People (a standardised measurement tool) at the beginning and the end of their work. This, along with the narrative of the worker, gives an indication of the changes that have taken place throughout the therapeutic process. The service has found this tool to be valuable for their assessments and helps them to be able to provide a service that meets the individual needs of children. Service users, their carers and professionals are asked to complete feedback forms. This information helps the service to think about how effective their service has been and how they can respond to comments made by the people who use the service. A comments box is also available which people are able to use, confidentially if they wish to make comments about any aspect of the service. Plans developed for their work are outcome focussed and are reviewed every 90 days.

In addition to demographic data, the service collects data about where the children they work with come from, their views about the service. This would include views about the direct service in relation to the worker, timing of sessions, accessibility, how welcomed people felt etc. The service learns about the views of the people who use the service and refer to the service. They are able to identify whether needs have been met or whether they need to make changes. This would involve looking at the data relating to the direct service and data given about the building.

Annex D – data sources for JSNA / needs assessment

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 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 VAWG resource	www.homeoffice.gov.uk/crime-victims/reducing-crime/violence-against-women1/index.html	Home Office website dedicated to Violence against Women. Acts as portal to a range of other information and websites where more specific information can be found
British Crime Survey 2009/10	http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1210.pdf	Crime in England and Wales 1009/10 Latest findings from 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. BCS 2008/09 contains this information within its main bulletin.
Domestic Violence, A National Report	www.crimereduction.homeoffice.gov.uk/domesticviolence/domesticviolence51.pdf	March 2005 – use with caution.
Police force level data	www.homeoffice.gov.uk/rds/ia/atlas.html	Police force-level data on recorded offences under principal offence categories by police district . Further information may be sought at a local level from local police forces or Crime and Disorder Reduction Partnerships.
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/prosecution/domestic/index.html www.cps.gov.uk/publications/docs/dvpilotsites0405.pdf www.cps.gov.uk/publications/docs/specialistdvcourts.pdf	These links are useful for obtaining an understanding of the issues surrounding prosecutions for domestic violence, and how decisions to prosecute are reached. There is also some evaluation of a pilot programme of specialist domestic violence courts. However, these documents do not contain any significant quantities of data and any data that is contained is largely out of date:
Population statistics – age	www.statistics.gov.uk/statbase/Product.asp?vlnk=15106	Age profile: ONS Mid-year population estimates for PCOs – latest available mid-2009
Population statistics – ethnicity	www.statistics.gov.uk/statbase/Product.asp?vlnk=14238	Ethnic profile: Includes estimates of ethnic population by PCO – latest available mid-2007
Child protection	www.dcsf.gov.uk/rsgateway/DB/SFR/s000873/FINALAdditionalTables1to13.xls	Information by local authority area on children subject to Child Protection Plans. Tables 10B and 10C show the number and percentage breakdowns by category of abuse
Ante-natal care	www.mqi.ic.nhs.uk/PerformanceIndicatorChapter.aspx?number=1.06 or www.nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx	VSB06 - Percentage of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.
NB This data on child protection and ante-natal care is the only relevant national data available. It can be used to give an estimate of need if local data is not available.		