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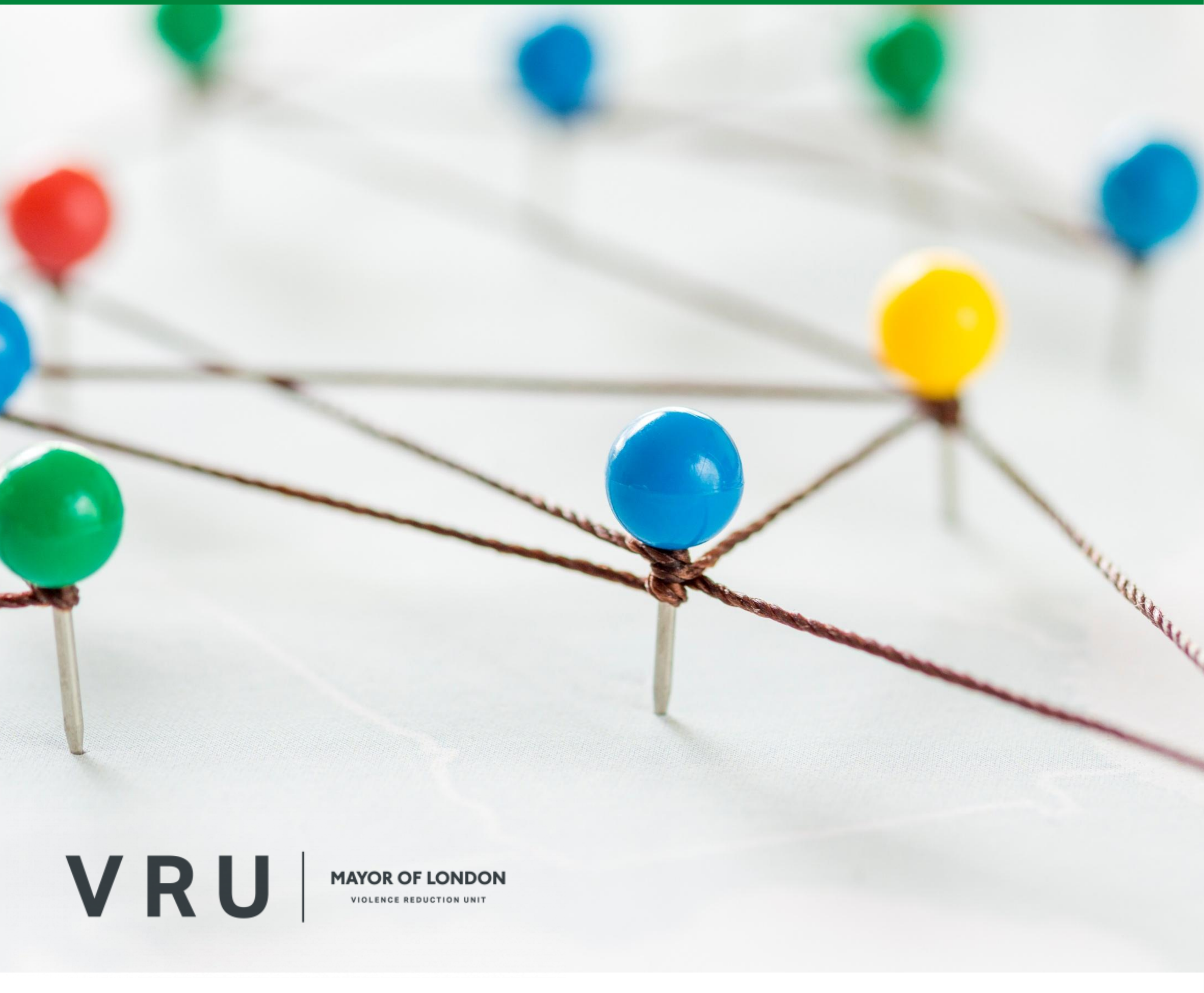
ADViSE Programme

Final Report



VRU | MAYOR OF LONDON
VIOLENCE REDUCTION UNIT

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List of abbreviations

AE	Advocate educator
BASHH	British Association for Sexual Health and HIV
DASH	Domestic Abuse, Stalking and Honour Based Violence Risk Assessment
DVA	Domestic violence and abuse
GBV	Gender based violence
GP	General Practice
ICB	Integrated Care Board
MARAC	Multi Agency Risk Assessment Conferences
STI	Sexually transmitted infection
SVA	Sexual violence and abuse
VRU	Violence reduction unit

Contents page

List of tables

List of figures

Executive Summary

What is ADViSE?

The ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments) programme is a pilot initiative developed by IRISi and funded by London's Violence Reduction Unit (VRU).

It ran in Homerton and Westminster hospitals and involved training within sexual health clinics to give clinical staff the skills to recognise service users experiencing Domestic Violence and Abuse (DVA) and Sexual Violence and Abuse (SVA).

As with other successful IRISi programmes, on-site Advocate Educators (AE's) worked in the sexual health clinics to provide a wide range of support to patients, including emotional, safety planning, and community referrals.

Why was it created?

ADViSE aims to help people who are experiencing SVA and DVA. It is part of wider work that IRISi do to try and reduce DVA working through GP clinics.

It was created to work in Sexual Health Clinics as SVA can lead to problems with sexual or gynaecological health.

Research also shows that more vulnerable people may use these services meaning it is important to work in these clinics to both identify and support patients experiencing SVA and DVA.

ADViSE also wanted to reach younger patients who might be using these services.

Measuring what has been delivered and the impact

Wavehill, working with peer researchers from Saint Giles Trust, was chosen by London's VRU to look at how ADViSE was working and the difference it was making for patients as well as the organisations involved.

Key figures

- 192 patients consented to being referred into the programme against a target of 110 across both sites.
- 163 patients started their first session.
- 91 clinicians were fully trained
- 82 clinicians were partially trained

“Having somebody there that understood everything made a big difference and made me feel safe.” Patient

How it has helped

ADViSE has been effective at finding new patients who are at-risk and helping services work together to better engage those who most need support.

The on-site AE was important in helping to improve patient support and staff capability. The training provided increased staff understanding and confidence, leading to higher identification of at-risk patients. AEs also played a vital role in building trusting trust, reducing barriers to disclosure, and engaging vulnerable groups.

The service is reaching the right people. This includes people from ethnic minority backgrounds, LGBTQ+ people, and individuals with mental health needs and younger people (under 25) who are more vulnerable to DVA and SVA.

ADViSE helped successfully identify patients who might not have received support otherwise. These were people who hadn’t accessed support before and weren’t likely to do so through more traditional clinical routes like GPs. 27 patients were referred to a MARAC (MultiAgency Risk Assessment Conference), which is a meeting where information is shared on the highest risk domestic abuse cases. This suggests operating in sexual health clinics is a good way to reach patients with experience of domestic abuse.

“It has been a fantastic programme...I would not be where I am now without them.” Patient

Outcomes and Impacts

Outcomes for Patients

Increased resilience, confidence and self-esteem

Patients who were interviewed said that the support had helped them to feel more resilient, confident, and improved their self-esteem. As a result of these positive changes, patients reported improvements in overall quality of life, feelings of safety and reduced risk of physical harm.

Accessing other support services

Patients reported accessing wider support services such as mental health, financial, or housing showing that ADViSE can play an important role as a vital entry point.

Feeling heard and less isolated

Staff spoke about how valuable the emotional support on offer was, as it provided a safe space and filled a crucial gap in existing provision. Patients reported feeling heard, listened to, and less isolated.

Impacts for families and friends

Patients said they were more confident about discussing challenges they were facing and talking about these with their family and friends which helped them feel less anxious.

Outcomes for Staff

Improved understanding

The training improved how well staff understood DVA and SVA and helped them to feel confident discussing these experiences with patients. This led to more patients being identified and referred, and meant risks were better identified and managed.

Increased confidence that patients would get the right support

An improved understanding also meant staff had a better awareness of support that's available meaning they were more confident they could refer patients to support that would help them. Having the AE on site also meant that there was support immediately available for patients. This was especially important for those who weren't in immediate crisis and therefore might not be able to get support elsewhere.

Relationships formed with support organisations

Clinical staff have formed good relationships with the support organisations that employed AEs which will continue.

Additional capacity

Before the programme the safeguarding team were responsible for referring patients. Having the AE helped take some of the workload off these clinical staff allowing them to focus on providing clinical support to patients.

The future

The ADViSE pilot funded by the VRU has come to an end, and delivery organisations were unable to secure alternative funding through the health system to continue delivery. While staff felt confident that learning from the programme would be sustained, they stressed the need for ongoing training as staff change over time and patients' needs will keep evolving.

The programme helped clinical staff to better identify patients at risk and ADViSE played an important role in supporting clinics to help patients experiencing SVA or DVA. The clinics have formed good relationships with the organisations that employed AEs, and these will continue however they will no longer benefit from having AEs based in the clinics

Recommendations

Opportunities for embedding key components of the model into standard practice

Embed capacity for advocate educators with specialist knowledge of the VAWG sector into safeguarding teams within clinics.

Embed elements of ADViSE training provision into ongoing staff training within the clinic.

Increase promotional activity for patients, for example, listing provision on clinic websites.

Contributing to a multi-agency approach to tackling domestic abuse and sexual violence

Formalise an ongoing relationship with external providers to ensure patients have access to clear pathways into wider support.

Consider the role the health sector can play in supporting and funding effective delivery models that strengthen pathways of support.

"In sexual health settings, disclosure of abuse happens in real time, in moments of trust and vulnerability. Without immediate specialist support, those moments are lost - and so are survivors." Clinical staff member

1. Introduction

1.1 ADViSE Delivery Model

The ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments) programme was developed by IRISi, a social enterprise aiming to improve the response of the health and social care sector to Gender-Based Violence (GBV). The IRISi (Identification and Referral to Improve Safety) programme was launched in 2017 as the first in a series of interventions aiming to support clinicians to identify and respond to the needs of patients who've experienced DVA in healthcare settings. Through the model, clinical staff working for GP services were provided with in-house training to better identify and support patients experiencing DVA, in addition to a designated point of contact (Advocate Educator) for patient referrals.

The ADViSE programme has been running since July 2023 in the sexual health clinics in Homerton Hospital in Hackney (hereafter referred to as Hackney) and St Mary's Hospital in Westminster (hereafter referred to as Westminster). Working with clinical leads within the clinics, ADViSE delivered training and provided referral pathways in sexual health clinics to help clinical staff recognise, address and make appropriate referrals on behalf of service users experiencing domestic violence and abuse (DVA) and sexual violence and abuse (SVA).

Advocate Educators (AEs) employed through the pilot worked within the clinical setting to provide patients with a wide-ranging support offer including emotional support, safety planning and referral to community support. They are employed by Advance in Westminster and NIA in Hackney and are available onsite Monday to Friday, with flexible hours aligned with clinic opening hours (e.g. evening availability on Wednesdays). Trained clinical staff complete a referral form detailing some demographic information, a brief reason for referral, and practical considerations such as safety to receive calls.

Referrals are made by trained clinical staff using a standardised form capturing demographics, a brief reason for referral, and any safety considerations (e.g. safe contact methods). When AEs are onsite, referrals can be made during patient appointments, allowing for immediate engagement or follow-up arrangements. When offsite, referrals are submitted via email, and AEs follow up with patients via phone within five days.

London's Violence Reduction Unit (VRU) commissioned Wavehill to evaluate the ADViSE Programme. This is the final summative evaluation report.

1.2 Rationale for the programme

Funded by London's Violence Reduction Unit (VRU), the ADViSE pilot contributes to the VRU's wider goal of fostering partnership-based approaches to understanding and preventing violence. In 2020, the VRU published its Strategic Needs Assessment which outlined its overall aims of reducing violence and creating security for children and young people through community-focused, partnership approaches. These strategic aims served as the basis for the funding of IRISi pilots, including ADViSE.

The VRU funded the delivery of IRISi across seven London boroughs between 2019 and 2022 (named IRIS 7B), with funding additionally being secured to deliver the model across a further four boroughs in 2022 (IRiS 4b). The success of IRISi 7B in identifying patients and increasing GPs awareness of, and confidence with issues related to DVA facilitated the VRU's funding of the ADViSE programme in 2022.[1]

The IRISi model's design was informed by wider research which identified healthcare facilities as prevalent settings for the presentation and/or disclosure of DVA. Studies demonstrate that people with experience of DVA were more likely to disclose details of abuse to health professionals before other professionals, highlighting its potential role in the earlier identification of DVA in patients.[2] Another recent study of reviews undertaken for a sample of people with deaths connected with DVA found that 89% (42 out of 47) of the deceased had at least one recommendation for the healthcare system.[3]

The estimated health service costs of DVA in London alone equals £433 million per year, and nearly half a million individuals in the UK experiencing domestic abuse seek assistance from medical professionals.[4] This figure also highlights the value of healthcare-based violence reduction interventions to the wider health and social care landscape.

The ADViSE programme was initially piloted in Tower Hamlets and Bristol in 2022 in order to build upon the IRISi model and expand its scope to clinical sexual health settings. The expansion of the service to sexual health clinics was, like previous models, informed by research pointing to these settings as relevant contexts for the identification and disclosure of DVA. For example, a report from the National Institute for Health Research demonstrates that almost half (47%) of women attending sexual health services will have experienced DVA at some point in their lives. The report furthermore found that women who have experienced DVA are three times more likely to have gynaecological and sexual health problems such as sexually transmitted infections (STI's) and unintended pregnancies.[5]

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[1] IRIS Programme - Identification and Referral to Improve Safety, DMSS Research, 2022
2 A Patchwork of Provision: Summary Report, Domestic Abuse Commissioner 2022
3 A Review of Health Recommendations Following a Domestic Abuse Related Death, Standing Together 2025
4 Whole Health London, SafeLives, 2023
5 Improving the response to domestic violence, National Institute for Health Research 2018

This research speaks to the underlying scope for clinical staff in sexual health settings to recognise and facilitate support for those experiencing DVA, who are disproportionately represented in the sexual health service user base. The ADViSE delivery model also facilitated a dual focus on identifying and supporting patients experiencing SVA as well as those experiencing DVA, owing to the association between sexual abuse and sexual or gynaecological health problems.[6] This enables the service to support a wider range of patients presenting at sexual health services with support needs.

In addition to patients experiencing SVA, the ADViSE model also held increased scope to reach patients from a wider range of groups and demographics than might be possible in GP settings. By providing services in sexual health clinics, the model aimed to identify and support younger patients (between the ages of 16 and 25); an age group which make up a significant proportion of users of sexual health services for reasons such as contraception.[7] In this way, the ADViSE model aims to provide an accessible point of support for young people and to contribute towards the VRU's strategic aim of increasing safety and security for this age group.

Research also suggests that people from more vulnerable groups within society may be more likely to be sexual health service users. For example, research from the British Association for Sexual Health and HIV suggests that those from a black and / or minority ethnic background and / or lower-income backgrounds are more likely to have sexual health complications, and subsequently frequently use sexual health services.[8]

Significantly, further research indicates that people who are a part of the above groups (including LGBTQ+ people) also have a higher vulnerability to DVA.[9] Within this, women from ethnic minoritised backgrounds are identified as especially vulnerable to DVA due to factors surrounding cultural expectations and norms, racism and complications around immigration status.[10] Collectively, these findings point to the potential of the ADViSE model to reach those who are most likely to benefit from support.

1.3 Evaluation aims and objectives

London's Violence Reduction Unit (VRU) engaged Wavehill as an evaluation partner for the ADViSE Programme. Wavehill subcontracted St Giles Trust, a charity working with vulnerable individuals, to utilise their experts by experience to support with delivery of fieldwork and advise on appropriate language and engagement activity.

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[6] Sexual and gynecological health in women with a history of sexual violence, IMR Press 2021
[7] Sexual and Reproductive Health Services (contraception) England, 2023-24
[8] 'We Need to Get Better at Sex', British Association for Sexual Health and HIV, 2018
[9] Responding to Domestic Abuse, BASHH Sexual Violence Group 2016
[10] Minoritised Ethnic Women's Experiences of Domestic Abuse and Barriers to Help-Seeking: A Summary of the Evidence, Scottish Government, 2024

The remit of this research included undertaking a detailed process and impact evaluation of the ADViSE Programme to help understand how the service is working, and whether services are delivering the results expected. More specifically, it aimed to look at the delivery through an intersectional lens, to assess how the pilot served diverse populations such as young people, LGBTQ+, and those from an ethnic minority background.

The evaluation aimed to:

1. Assess the core deliverables of the programme through appropriate performance monitoring and analytics including referrals, throughput, engagement, and demographics.
2. Examine the process of implementation to understand the views of those involved in the interventions (including staff, users and healthcare professionals) and to identify key learning to help drive improvements to implementation, reviewing key lessons, strengths and barriers.
3. Examine the indicative impact of the programme to understand the potential benefits that the interventions/programme has had for those involved, and to assess whether the programme has met its aims, both at an organisational level and for individual patients.
4. Identify the key mechanisms which impact the success of ADViSE, informing a toolkit to share best practice on the implementation of ADViSE in other locations.

In addition, the evaluation aimed to assess contributions made towards the longer-term VRU impact goals as outlined in their Outcomes Framework[11], which are to ensure:

- Violence is stabilised and reduced
- Children and young people feel safer
- A community focused, partnership approach to long-term, sustainable violence reduction solutions

Specifically, the programme can be assessed against the following VRU outcomes for individuals experiencing harm and the organisations supporting them:

- Increased ability for professionals to identify and support those who have experienced or witnessed domestic abuse
- Increased clinical awareness of domestic abuse referral pathways
- Improved practitioner response to safeguarding risks
- Increased support for those impacted by domestic abuse/violence

More detail regarding the specific outcomes of the ADViSE pilot can be found in the logic model in the appendix.

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[11] London Violence Reduction Unit Outcomes Framework, 2022

1.4 Research Method

Governed by the UK Government's Magenta Book[12] on evaluation design and Aqua Book[13] on quality analysis, this is a theory-based evaluation. Qualitative data analysis was also underpinned by Grounded Theory methodologies[14], ensuring systematic and inductive processes were adopted. This evaluation has been undertaken between August 2023 and July 2025 and has included the following activity of both qualitative and quantitative methods:

- Desk based review of the existing evidence base to assess learning from similar interventions and to inform understandings around patient needs. The review also explored cultural and group-specific experiences of DVA and SVA and identified the barriers people may face to accessing support
- Co-production of an evaluation framework to outline the evaluation processes in alignment with the key research questions. The framework was co-produced with the project team to develop a mixed-method methodology best suited to reflect project success and progress against outcomes
- Review of quarterly monitoring returns for the lifetime of the project to March 2025 and supplementary progress reports provided by the VRU and provider organisations, including training feedback
- Semi-structured interviews with delivery staff at two points to understand efficacy of delivery and impact, including:
  - The two Advocate Educators from both hospitals
  - The two clinical leads working with ADViSE from both hospitals
  - The two delivery providers managing ADViSE: NIA and Advance
  - Seven clinical staff referring into the project at both sites
  - Three wider IRISi ADViSE management staff members
  - One safeguarding lead
- Structured interviews with three patients at the interim phase (from Westminster) and 11 at the final phase (with three from Westminster and eight from Hackney) to understand the impact of engagement
- Visits to both sites in early 2025 to understand the patient journey and engage with staff involved

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[12] UK Government, The Magenta Book, 2025

[13] UK Government, The Aqua Book, 2023

[14] Bryman, A., quantity and quality in social research London rouytledge1998, Charmaz K,. Grounded Theory: objectivist and constructivist methods, in N.K Denzin and Y S Lincoln (eds) Handbook of Qualitative Research 2nd Edn, Sage.

Given the sensitive nature of the support, patient discussion guides (available in the appendix of this report) were stress tested with two lived experience peer researchers prior to dissemination and both the interim and final phase. This was to ensure appropriate language and terminology was used, to encourage candid responses that did not require re-disclosure of experience.

Informed consent was collected from patients via AEs prior to any engagement with evaluators, to ensure full understanding and willing to engage. Further, AE's approached appropriate patients (namely those that were not at immediate risk) to engage with the evaluation to obtain informed consent and passed on their contact information and engagement preferences to the evaluation team. Whilst required given the sensitive nature of support, this may have limited sample size availability.

Patient interviews were conducted via a St Giles Trust peer researcher with lived experience, to encourage engagement through mutual experiences and understanding. A trigger warning was also included with the option to withdraw at any time, along with a privacy notice to clearly explain how data would be used.

1.4.1 ADViSE delivery evaluation activity

In order to explore patient experiences with the ADViSE service and identify any outcomes gained outside of the evaluation, AE's distributed feedback forms at case closure and collected anecdotal evidence through case studies. In total nine feedback forms were collected by staff (five in Hackney and four in Westminster). This information has been analysed to complement evaluation activity and further identify impact. It should be noted that it is not possible to confirm if the same patients have responded to both requests for feedback.

Feedback forms were disseminated at the end of training sessions to give staff the opportunity to relay their thoughts regarding the content of the training and their learning. A total of 69 staff provided feedback out of 173 at the point of being partially trained, and 28 out of 91 responded at the point of being fully trained. It is important to note that it is possible the same individuals fed back at both points, and thus the total number of unique responses is not clear.

1.5 Methodological Limitations

Whilst our evaluation has adopted a mixed methods approach to provide a robust assessment of the ADViSE programme, it has faced a range of methodological limitations. Importantly, given the sensitive nature of topics and personal experiences, it is common to experience complex barriers to engagement with evaluations of this kind, as researchers may often be viewed as another professional requiring patients to discuss their experiences.

1.5.1 Patient Engagement

A key limitation of this evaluation is the small sample sizes, with the nature and scale of the service being contributing factors. ADViSE is not only a pilot, but is a service operating in a complex, sensitive and confidential setting. Patients disclosing DVA and SVA may lack trust in services and could have hesitance in speaking with professionals, including researchers. For these reasons, despite efforts from AEs, patient engagement in participating with the evaluation produced small sample sizes and therefore findings should be interpreted within this context. An anonymous online survey was also developed to encourage engagement, but response levels remained low. Similar challenges have been noted in evaluations of comparable programmes.

1.5.2 Staff and Stakeholder Engagement

Another limitation to the evaluation is the sample size of clinical staff feedback to the training they received. The response rate was generally low and is likely due to prioritisation of workloads.

1.5.3 Monitoring Data

Another key limitation to the evaluation is the consistency and overall quality of the quarterly monitoring data collected. Part of the data quality issues were due to the use of multiple systems and internal provider databases, which increased the risk of data quality issues during data transfer. Namely, AEs were required to input data into clinic patient systems, as well as their existing provider systems. Provider managers then were required to use such data to inform VRU monitoring reports. Monitoring forms were refined during delivery following discussions between the VRU and delivery partners, which led to improved data quality over time.[15]

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[15] As part of the evaluation process, data discrepancies have been identified, and this is due to local ADViSE data and OASIS ADViSE data not aligning. These discrepancies are being reviewed, and an addendum report will be provided to address this.

2. Programme Delivery

Key findings

- Key strengths of the model included the training programme for clinical staff, the provision of face-to-face patient support through AEs and the embedding of the AE role into clinical teams.
- The programme has overachieved with regards to patient engagement, with 192 engagements being made against a target of 110. This points to the efficacy of the programme as an initial point of contact for patients experiencing DVA and / or SVA.
- The project successfully identified patients in need of DVA interventions, who likely would have otherwise gone without identification and support. Namely, diverse groups have engaged such as LGBTQ+ and those from ethnic minority backgrounds.
- 91 staff were fully trained throughout the programme, with 44 staff being partially trained.

The next section looks at how the programme was delivered, identifying key strengths and challenges.

2.1 Patient engagement

The programme has surpassed engagement targets across the lifetime of delivery, engaging 192 patients (107 in Westminster and 85 in Hackney) against a target of 110 across both sites. Engagement has been consistent since April 2024, after aforementioned delays to mobilisation of the programme, until early 2025 when providers started prioritising existing patients to shift their focus to programme closedown.

Table 2.1: Total programme reach

Site	Number of Individuals Reached			
	Under 25	**25+**	**Age Unknown**	**Total**
Hackney (Hackney)	16	65	4	85
Westminster (St Mary's)	20	84	3	107
Total	**36**	**149**	**7**	**192**

Source: ADViSE Monitoring data

Of the 192 engagements recorded (those consenting to be referred), table 2.2 shows that a total of 163 successful referrals (those that attended their first session) have been made throughout the lifetime of the project (73 at Hackney and 90 at Westminster). Up to programme closure in March 2025, 30 patients had completed their engagement and had their cases closed.

Table 2.2: Throughput of patients

Site	Referrals	Repeat referrals	New Engagements	Disengaged	Completed
Hackney (Homerton)	73	6	68	31	23
Westminster (St Mary's)	90	3	87	21	7
Total	**163**	**9**	**155**	**52**	**30**

Source: VRU Monitoring data.

Of the successful referrals across both sites, 32% (52) patients disengaged throughout the programme, of which 48% (25) declined support and 38% (20) did not engage. With some data gaps present in monitoring data, it is not possible to accurately break down disengagement reasons by site, however progress reports indicate that the majority of said patients had accessed clinical services in Hackney.

It is important to note that it is likely there were a range of reasons for declining support. For example, personal circumstance such as living and financial situation, as well as propensity to discuss or take action at the time of attendance at the clinic. Anecdotally, some referrals were also deemed too high risk by safeguarding teams within the clinics, owing to their current situation, and were therefore referred to appropriate services and listed as disengaged.

2.2 Patient profile

Patient profile data was available from IRISi monitoring data (MI), and enables analysis of demographics per individual patient, across both sites.

Findings from monitoring data and staff interviews indicates that the service is reaching its targeted user groups, with these primarily being identified as groups who may be more vulnerable to, and more likely to experience DVA and SVA. This includes a wide range of audiences including, but not limited to, those from ethnic minority backgrounds, LGBTQ+ people and people experiencing mental health difficulties.

In terms of gender, patients largely identified as female (78% in Westminster and 93% in Hackney). This is slightly over-represented compared with the most recent NHS statistics around contacts with Sexual and Reproductive Health services, which saw females make up 75% of all users in 2022/23.[16] With that said, staff and stakeholders felt that more male identifying patients were disclosing experience of DVA and SVA than had been prior to the programme.

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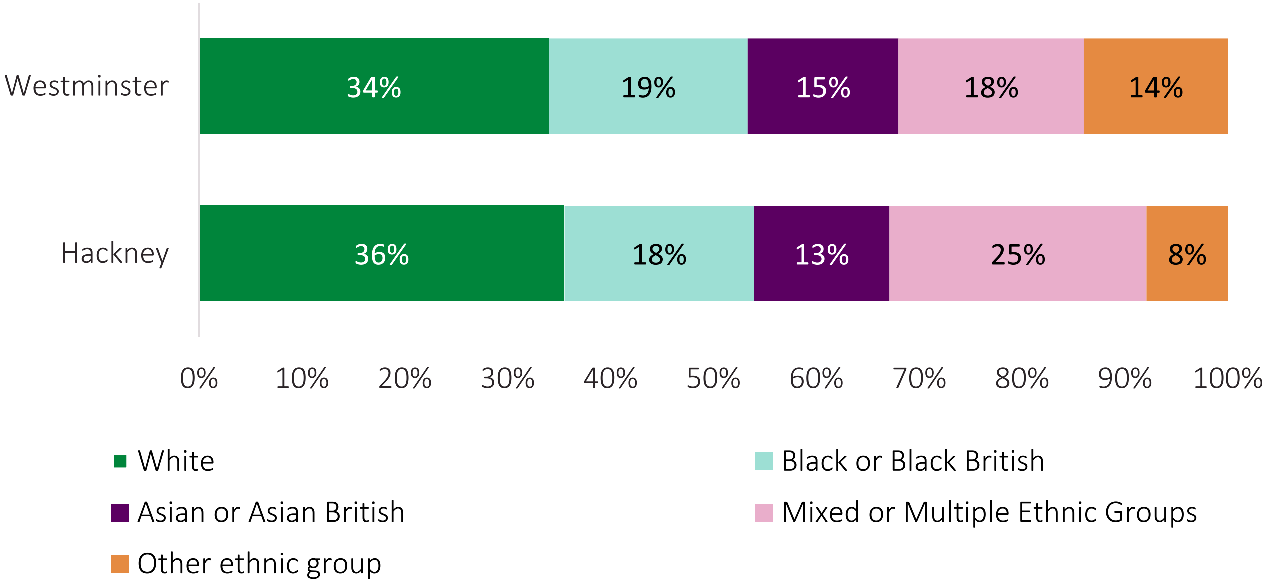
[16] Number of individuals in contact with sexual and reproductive health services in England, 2022/23, NHS

Data available on ethnicity demonstrates a diverse patient reach, especially in comparison to the population. In both locations, the largest proportion of patients identified as white, however those from ethnic minority backgrounds were overrepresented in this cohort compared to the local demographic. For example, patients identifying as Black or Black British represented 19% of the cohort in Westminster and 18% in Hackney, compared to 8% and 6.5% in the population respectively. [17][18]

Figure 2.1: Ethnicity of patients



Source: IRISi Oasis monitoring data, N= 150

These findings are significant within the context of the multiple barriers those from Black and Ethnic Minority backgrounds may face towards disclosing instances of DVA. Recent research from 2024 suggests that such individuals may perceive themselves to be at risk of social and / or community stigma and racism from service providers, which may prevent them from disclosing.[19] This reinforces the continued need for service providers to hold awareness of the various cultural challenges different groups may face and implement measures to help reduce these barriers. Further, this aligns with previous research, denoting that those from ethnic minority backgrounds are more likely to experience domestic abuse[20].

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[17] ONS, 2021 Census

[18] ONS, 2021 Census

[19] Asante, B.O., 'Service providers' perception of Black immigrant domestic violence survivors' use of support services' (2024)

[20] 'We Need to Get Better at Sex' Infographic, British Association for Sexual Health and HIV, 2018

Monitoring data further demonstrated that 23% of patients across both sites were recorded as non-UK nationals, which is a higher proportion than the respective figure for England and Wales at 18%.[21] Interviews with staff further corroborate that the service is being accessed by those who may have recently moved to the UK and may be in a vulnerable or insecure living situation.

The age of patients was largely over the age of 25, with one fifth of all patients below this age. This is likely owing to the available alternative provision for this cohort within the clinics such as RedThread, thus indicating that whilst not engaged with ADViSE, this cohort does have access to support. Whilst the younger cohort engaging is smaller than anticipated, available VRU data indicates that ADViSE is reaching a larger proportion of this cohort than IRISi 4B and 6B delivery in GP surgeries, which engaged 6% and 4% of those aged 16 to 24 respectively. The age distribution of patients varied between the two sites, with the largest proportion in Westminster being those aged 36 to 45 (32%) compared to those aged 26 to 35 (38%) in Hackney.

Figure 2.2 Age breakdown of patients

Source: IRISi Oasis monitoring data, N= 182

Across both sites, the majority of patients disclosing religious views followed no religion (47% in Westminster and 58% in Hackney). There was prevalence of both Christianity (37% in Westminster and 14% in Hackney) and Muslim faith (14% in Westminster and 19% in Hackney) amongst patients, suggesting the importance of understanding the level of need for cultural considerations required through delivery and how diversity impacts experience, as well as within training.

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[21] ONS, 2021 Census

Looking at sexuality, the majority of patients engaging (83% at Westminster and 86% at Hackney) identified as heterosexual. Patients identifying as gay, bisexual and pansexual were overrepresented in-patient samples for both sites, representing 13% of patients at Westminster and 8% of those at Hackney, compared with 3.2% of the London population.[22]

The prevalence of LGBTQ+ patients was also reflected in staff interviews, with staff commenting that the programme was resulting in improved support offers for LGBTQ+ patients and was helping to reach members of the community that previously may not have engaged in the offer. Linked to this, staff highlighted the importance of maintaining strong relationships and referral pathways with specialist services to ensure that LGBTQ+ patients and patients from other target groups can continue to access tailored support that meets their needs.

In Westminster, 3% of patients identified as having a disability, with the respective figure for Hackney being 17%. Patients with disabilities are under-represented within both samples when compared with the 24% figure for the overall UK population.[23] However, two-thirds of patients at Westminster (66%) and 56% of patients at Hackney were reported to have a mental health need, with the most prominent conditions being depression and anxiety across both sites. These figures are important when considering the service requirements for patients and aligns with anecdotal comments regarding the commonality of mental health and emotional support needs through the service.

2.3 Patient needs

Delivery providers initially expected the focus of the programme to be supporting those experiencing sexual violence, however, there has been a greater number of DVA disclosures than anticipated. Monitoring data confirms this, with the primary reason for referral being DVA for 60% (113/169) of patients.

In terms of type of abuse experienced by ADViSE patients, the most common form of abuse reported was emotional abuse which affected approximately two-thirds of patients referred across the sites, which aligns with the commonality of support delivered.

Physical abuse was experienced by just over half of patients that were referred at both sites. It is important to note here that experiences of abuse are not exclusive, and an individual may have experienced multiple types of abuse. Whilst financial abuse was less prominent, staff interviews identified financial pressures and poverty as an enabling factor of abuse for many patients.

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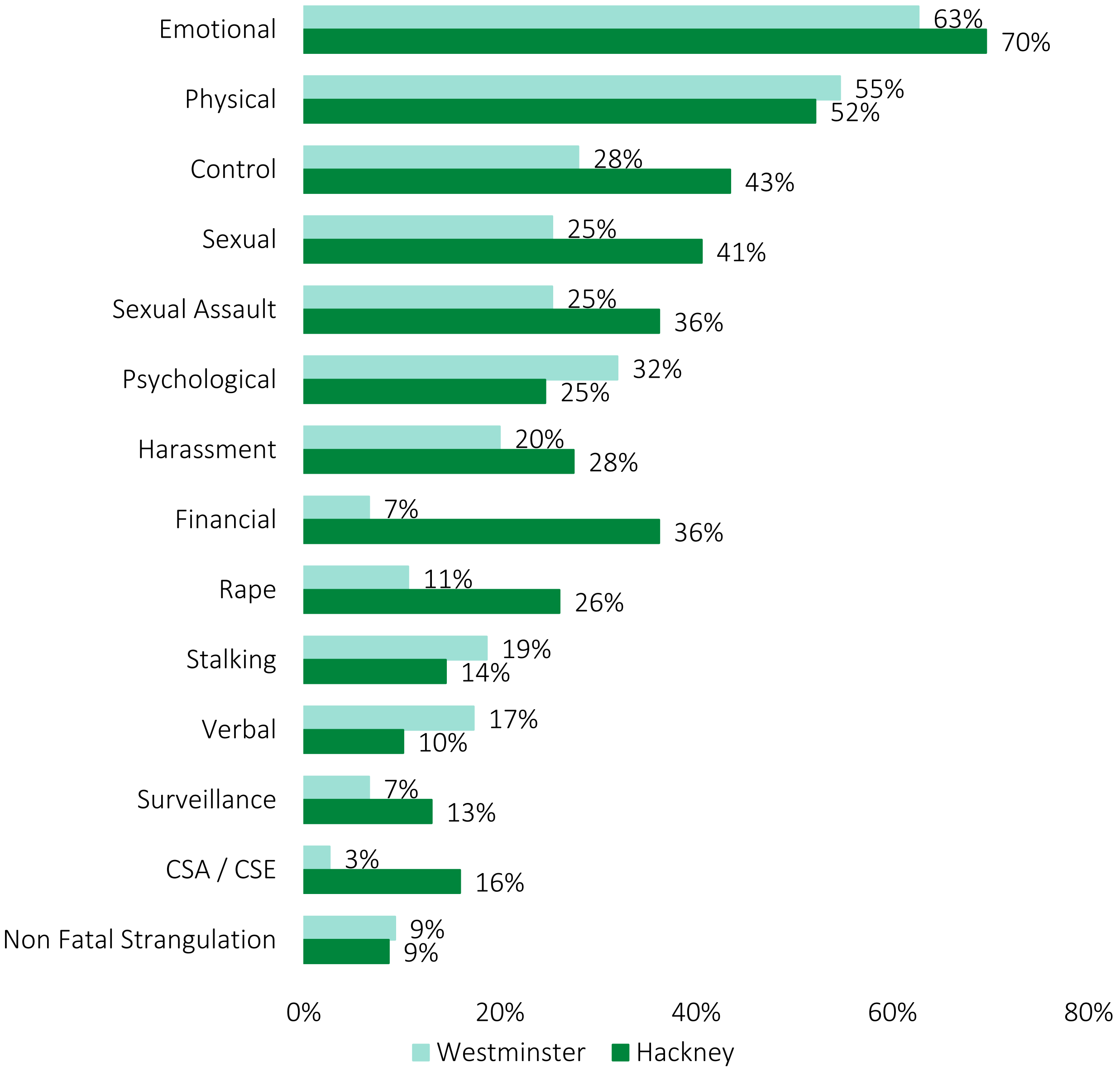
[22] Sexual Orientation, London, 2021 Census, ONS

[23] Family Resources Survey, 2022 to 2023

They noted how it increases people's vulnerability to abuse where present and can trap them within situations in which they do not have the means or resources to remove themselves from. With that said, they further indicated that financial abuse was not exclusively experienced by those experiencing financial pressures.

Figure 2.3: Types of abuse

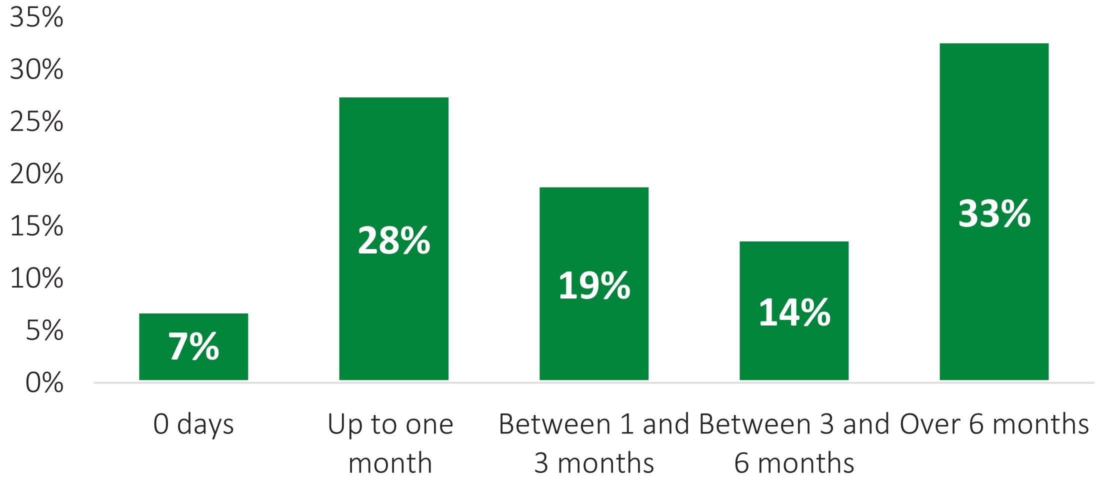


Source: IRISi Oasis monitoring data, N= 144 (Westminster n=75, Hackney n=69)

Patients interviewed received support for a wide range of needs, with the most common forms including emotional and mental health support and having someone to listen to them. This aligns with comments from delivery staff, whereby an increasing need for mental health support has been identified. Another common need involved support with signposting and referral to other organisations for more specialised and specific forms of support, underscoring the need for a dedicated member of staff to focus their capacity on delivering and referring to social support.

Whilst data regarding the number of sessions is not available for all patients, data available for around 50% of patients suggests that on average, patients met their AE two to four times before closure. For those with an engagement closure date (around 30% of all engagements, largely from Hackney), the average time spent on programme was around four months, however this did vary greatly as shown in the figure below. Staff consistently noted that length of engagement greatly depends on the need of the individual, underscoring the importance of a bespoke, flexible support offer.

Figure 2.4: Length of time on programme



Source: IRISi Oasis monitoring data, N= 58

AE's conduct a Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment (DASH) risk assessment to identify the level of risk for patients. Outcome data available for 69 patients indicated that the majority (65%) were deemed medium risk cases. The data further reports that a total of 27 new Multi Agency Risk Assessment Conferences (MARAC)[24] referrals were made across both sites, and an additional nine patients engaging were already known to MARAC. This is key in understanding the role that sexual health clinics can play in identifying risk and providing a reachable moment of support access for those who may otherwise not have access.

Patterns regarding risk were similar across both sites, however less data was available for Westminster. This suggests that the programme is identifying new patients that are at risk and require formal intervention, contributing to aims of better identifying patients that are at risk, through a multi-agency, partnership approach.

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[24] A meeting of multiple services to share information and discuss high-risk domestic abuse cases.

2.4 Staff Engagement

A key aspect of programme delivery was staff training. This included delivering two training sessions to clinical staff, and one session to non-clinical staff such as receptionists. The training content has had a clear focus on domestic and sexual abuse within a sexual health setting, while remaining flexible and responsive to emerging topics. For example, including changes to the law and information around non-fatal strangulation and how bruising may appear on black and brown skin.

Across the programme lifetime, the programme engaged 206 professionals across the two sites. A total of 82 clinicians across both sites have been fully trained whilst a further 91 have been partially trained, whilst 33 non-clinical staff received training. It is difficult to ascertain the proportion of all staff this equates to, owing to the changeable nature of staffing within the clinic due to doctor rotation and staff turnover. This underscores the importance of ongoing training provision, to encourage widespread implementation of learning.

It was further noted availability of staff time was a barrier to engaging with training. Sessions were delivered in person, but clinical staff could only attend in their free time, also requiring them to take this time back, which was difficult for many. That said, clinical leads were confident that engagement with training was widespread within the clinics, and efforts were made to engage. Available monitoring data indicates that 59% of referrals came from fully trained clinicians, whilst the remainder were referred by those partially trained, suggesting that partial training does still equate to sustained engagement.

Table 2.3: Staff trained

Site	Clinicians (Fully Trained)	Clinicians (Partially Trained)	Non-Clinicians (Trained)
Hackney	42	37	7
Westminster	49	45	26
Total	91	82	33

Source: VRU monitoring data

2.4.1 Project promotion

The programme has been consistently promoted amongst staff within the clinics, through AE's and clinical leads. There was widespread awareness amongst staff members about programme delivery, and the positive impact it has had on patients and staff learning. This was evident from discussions with staff both in interviews and at site visits.

More broadly, clinical leads have regularly attended British Association for Sexual Health and HIV (BASHH) meetings to promote the programme and support embedding it into sexual health settings.

2.5 Effectiveness of the model

2.5.1 Strengths of delivery

Overall, the programme ran as expected and exceeded the expectations of delivery partners with consistent engagement from clinical and non-clinical staff, and a strong level of engagement from patients across both sites. Importantly, the role of the clinical lead enabled the championing of the programme internally by a trusted person within the clinics, promoting engagement and embedding of the pilot within the clinical setting. The role supported the galvanisation of connections between the clinics and non-statutory organisations, which had been limited prior to delivery.

Staff interviews indicated that on the whole, training has made staff within the clinic feel better equipped to engage with and discuss scenarios surrounding abuse with patients. Clinical staff explained that the training was largely reflective of their needs, providing ‘hot topic’ training such as how to approach patient confidentiality and report risks to Multi-Agency Risk Assessment Conferences (MARAC). Some noted that there would be benefit in further tailoring training, to ensure accuracy for within a sexual health setting rather than a GP setting. Namely, a localised focus on sexual violence. This would enable ADViSE training to encompass broader aspects of training required of clinical staff, subsequently streamlining training provision.

The face-to-face provision of support was identified by both staff and patients as especially vital to making patients feel secure and comfortable with maintaining an open dialogue with service staff. Patients also identified assistance with completing paperwork such as referrals to police and legal services as particularly helpful.

Particularly at Westminster, the AE role has been embedded into the safeguarding team’s pathway, supporting continuity of processes when the AE is not available. Further, AE engagement with meetings and patient discussions (as referenced later in the report), has supported the embedding of their role into clinical delivery. Staff cited how this supported a patient focused approach, with on hand advice from a non-clinical individual.

There has also been close working with safeguarding colleagues and AEs to set up a group to look at implementing pathways and guidance regarding non-fatal strangulation. These initiatives were prompted by wider discussions around levels of awareness amongst clinical staff around non-fatal strangulation and identified the potential for improved referral pathways with clinical staff to facilitate the appropriate identification and treatment of patients. Such partnerships are hoped to influence the health sector around the importance and purpose of the programme within sexual health settings.

2.5.2 Key challenges

A longstanding challenge of delivery has been resourcing of staff. As identified at the interim phase, mobilisation was slow due to the requirement for honorary NHS contracts and exacerbated by changes to AE staff in the early stages of delivery. Subsequently, this had a lasting effect on the programme as the delivery window was shortened. With that said, supported by consistent buy-in from both delivery providers and clinical leads, engagement has proved consistent throughout the lifetime of delivery, as discussed in more detail in the performance section of this report.

Some staff cited that only having one AE per site poses continuity challenges and increases the risk of gaps in delivery throughout sickness, annual leave periods or in line with delays to recruitment. Whilst the pathway for patient support was safeguarded in that referrals went through the safeguarding team; there was still limited capacity within this team to deliver the same level of support as that of the AE. This was seen to potentially disrupt continuity for the patient, which may have been a barrier to continued engagement, supporting the rationale of having dedicated specialists embedded within the safeguarding teams of the clinics. Whilst this was challenging, a strength of the well-established delivery model and experienced providers was that caseloads could be absorbed into delivery partner capacity, limiting the disruption for patients.

Whilst early impacts have been identified (as discussed later in this report), the pilot faces challenges in capturing longer term outcomes for patients referred for further support. Although referral details are logged in ADViSE's OASIS monitoring system, staff noted that the system is not designed to record longer term impacts. This undermines the pilot's ability to evidence broader impacts , including increased feelings of security and violence reduction on both an individual and community level, and may have resulted in under reporting of impact.

As previously highlighted, AEs were required to input patient data into both IRISi and hospital systems. It was felt that with the large caseload, this led to gaps in data. Where gaps were present in hospital systems, this was challenging for clinical staff in understanding patient journeys as they did not have access to IRISi systems. With that said, staff commended AEs for their availability in person to provide informal updates as required.

3. Outcomes and Impacts

Key Findings

- Feedback from staff, stakeholders and patients has suggested that the ADViSE programme is bringing a wide range of positive outcomes, both for delivery staff and for those using the service.
- The support was used by patients who hadn't accessed support before and was effective at enabling patients to access wider support services. Linked to this was indications that the support had increased patients' trust in services and worked to counter negative perceptions and experiences of healthcare and public services.
- Patients reported positive impacts including improvements to mental and physical health and quality of life; impacts which had extended to friends and family members.
- Staff feedback indicates improved knowledge of, and confidence with navigating processes around the identification of DVA and the use of referral pathways.
- Wider reported impacts included the building of capacity for clinical staff and the facilitating of multi-disciplinary working and learning across clinics.
- Whilst learnings and referral pathways are sustained beyond the programme's end, the lack of longer-term funding may affect the programme's longer-term impact.

The following section reports on the impacts of the programme, on both patients and staff involved, and the contributions made to the overall aims of the programme.

3.1 Outcomes for patients

Whilst feedback was collected from a small sample of patients through patient interviews, complemented by a small number of responses to delivery provider patient feedback and case studies, the findings provide a valuable insight into the impact of the support on patients, their overall quality of life and that of their family and friends.

The smaller sample size however means that comparison between outcomes for patients attending the Westminster and Hackney sites is not possible, and impacts explored reflect on the programme as a whole. Further, findings are more indicative of impact for those responding, rather than representative of the full cohort of patients engaging.

3.1.1 Awareness of service provision

Patients reported that service engagement had led to an increased awareness of the forms of support available to them, as well as increased knowledge of how to access support. Available monitoring data indicates that 70% of patients had never tried to access support previously, whilst 5% had tried and been unable to access the support they needed, suggesting the support is reaching those who otherwise would not get support.

Whilst patients were not asked to give reasons for this, wider research as previously mentioned has evidenced that those experiencing abuse may experience a wide range of barriers to accessing support, including fear of social stigma and a lack of knowledge around how to access support. Feedback from staff reports similar, explaining how the service has reached those who had not been in receipt of any support at the point of contact, and those who were unlikely to receive support from other clinical services such as GP services.

As highlighted earlier in the report, interview responses indicate that the role of the AE was crucial to engaging patients within this group, as it facilitated face-to-face engagement and enabled patients to liaise with a singular point of contact. This helped to build up trusting relationships with patients and reduced barriers to disclosure. This corroborates the notion that the service is helping to engage groups that historically may have been underserved by statutory services and those who may have experienced barriers to accessing services. Further, such increased awareness of what services may be available and may encourage them to seek out support in the future.

> “It has had a big impact on those that weren't accessing support prior to the programme. It's reaching a different demographic**.” Clinical staff member**

Whilst interviewed patients cited increased awareness of available services, some suggested that there would be benefit in raising the profile of ADViSE. It was felt that that the service has the potential to tap into a broader base of those experiencing DVA and SVA. This may constitute a rationale for future programmes to advertise the service beyond a clinical sexual health setting, and to develop a wider referral network.

> “I wish there was more knowledge about this. I believe a lot of people could get the help they need to improve their situation.” **Patient**
>
> “(Suggest) making the service more known about as I wasn't aware of it until quite late in my journey.” **Patient**

Interviewed patients reported that in accessing support through ADViSE, they have felt more able and motivated to access wider forms of support moving forward. For example, the majority of respondents report that they have been able to access wider support services following their engagement, including mental health, financial and housing support services. Of nine interviewed patients responding, five reported that they wouldn’t have accessed these services if they hadn’t initially been involved with ADViSE. This suggests that in addition to addressing patients’ immediate support needs, ADViSE has acted as a crucial point of initial contact between patients and services and has helped to increase the reach of wider holistic services.

On a longer-term basis, this may enable patients to reduce the range of risk factors which may increase their vulnerability to DVA and SVA and helps to sustain their longer-term security.

3.1.2 Meeting patient needs

Patients reported high satisfaction with the programme, noting that it had successfully supported their wide-ranging needs. All 11 patients interviewed agreed that the support helped them to get what they wanted or needed, such as emotional and practical support, with nine of those reporting this to a great extent. Staff responses highlighted the value of the emotional and therapeutic support in particular, reporting that it gave patients a safe place to discuss their feelings and experiences and filled a gap in standard support provision.

> "(They) offered clarity on the issue...validated my feelings and decisions and called frequently to check in. I didn't feel like I was left to fall through the cracks, which meant a lot." **Patient**

Respondents across varying support needs stated their appreciation that the AEs held oversight of their case, which reassured them that a professional was monitoring their emotional state and checking up on their wellbeing. Importantly, this enabled patients to feel heard, listened to and that they were not alone. This may reflect wider themes (to be discussed further in the next section) around patients feeling less isolated as a result of their engagement. More broadly, this contributes to the overarching aims of accessing holistic support.

3.1.3 Levels of trust in services

Some patients cited how the engagement with support has enabled them to build a more trusting relationship with staff. For example, all patients providing staff with feedback at case closure (nine patients) indicated that they were pleased that they had been referred to a specialist worker and felt listened to throughout their engagement.

One patient compared their experience with ADViSE favourably against previous experiences, stating that they felt able to talk to them when previously they 'held everything in' and sometimes would feel 'judged' when talking to other professionals. This was reinforced by staff reporting that users felt that their feelings were 'validated', potentially for the first time since experiencing abuse. Such findings suggest that the service may have helped to counter any less positive experiences with other services and has further helped to develop a base of patients who may otherwise have not accessed support.

> "It has made me realise that there are people there to help you and guide you through the more complicated processes, like navigating housing."
> **Patient**

> “(It) made me realise there is someone who understands, will listen and will help through the bad times.” **Patient**

Monitoring data indicates that there was an average of three days between referral receipt and attempted contact with the patient, whilst the average amount of time between referral and actual contact with the patient was twelve days. It is important to note that whilst 32% of patients were engaged after one contact attempt, a further 46% required between two and five contact attempts prior to engagement, whilst 27% required over five attempts. Further, whilst referral takes place on site, the time lag between referral and engagement may indicate that the programme is less of a ‘reachable moment’, rather an important pathway towards further support.

Ten out of eleven interviewed patients reported that they felt they received support within an appropriate timescale, with the service keeping the amount of time elapsed between referral and patient engagement to a minimum. Staff cited this as an enabling factor towards building up trust in services, as it reduces the chances of patients becoming distressed following their referral and demonstrates that their wellbeing is a priority for the service. This is important when building longevity of the service, as increased trust may increase longer term engagement, and subsequently better supported patients and less risk of harm.

3.1.4 Impact on wellbeing and feelings of safety

Patient feedback suggests they experienced a wide range of positive impacts as a result of their engagement, including improvements to physical and mental health and general improvements to their quality of life. Patients reported that the support has enabled positive improvements in their lives. For example, nine out of eleven patients reported that they felt more supported, whilst eight out of nine respondents reported that they felt less isolated as a result of the support.

Other feedback indicates that the service led to increased feelings of security and decreased levels of vulnerability to risk, with respondents reporting that they felt less at risk of physical harm at least to ‘some extent’, and others reporting feeling safer a result of the support. Increased feelings of security were linked to increased feelings of inner peace, indicating the wider impacts of the support on patients’ emotional wellbeing and state, in line with aims.

> “Having somebody there that understood everything made a big difference and made me feel safe.” **Patient**

Additional positive impacts of the support on patients’ mental wellbeing included increased degrees of mental and emotional resilience and increased confidence and self-esteem.

These were reflected within patient feedback, where patients commonly stated that the support helped them to get through every-day life and helped to inform them that it was possible to work towards greater quality of life with support. Such findings are significant in improving the wellbeing of a patient and can contribute to sustained emotional wellbeing moving forward.

> "It has given me more of a point to life I feel that I can get through this." **Patient**
>
> "I keep reminding myself that I can carry on that life is worth it." **Patient**

Patients have also reflected that their experience with ADViSE has helped them to adopt a more positive and optimistic outlook on their future. For example, patients reported a greater sense of being supported, increased self-esteem, feelings of security and a decrease in vulnerability to victimisation. These findings help to illustrate the legacy of the support by demonstrating the service's capacity to reshape patient perspectives on life and to encourage them to work towards recovery beyond their engagement.

> "It has been a fantastic programme, and I am very grateful for the support I received. I would not be where I am now without them." **Patient**

3.1.5 Impact on patient's wider network

Of the interviewed patients, nine stated that the support had some impact on the people around them, as a result of the positive impacts experienced by patients. Patients reported that they felt more confident and able to discuss their challenges and vulnerabilities with loved ones. This has enabled them to be aided by a wider support network and reduced anxiety amongst families and friends who now feel more informed around their situation. Some cited that the support enabled them to build healthier and more communicative relationships with their children. Some further felt it has enabled them to focus more on their parental role through alleviating safety concerns and improving mental wellbeing.

> "It has helped me talk to my son and explain what has happened to me… it's allowed us to have a better relationship and helped him to understand more." **Patient**
>
> "It made (my) mum, brother and friends feel a lot less worried and alleviated safety concerns. (They were) relieved support was being given." **Patient**

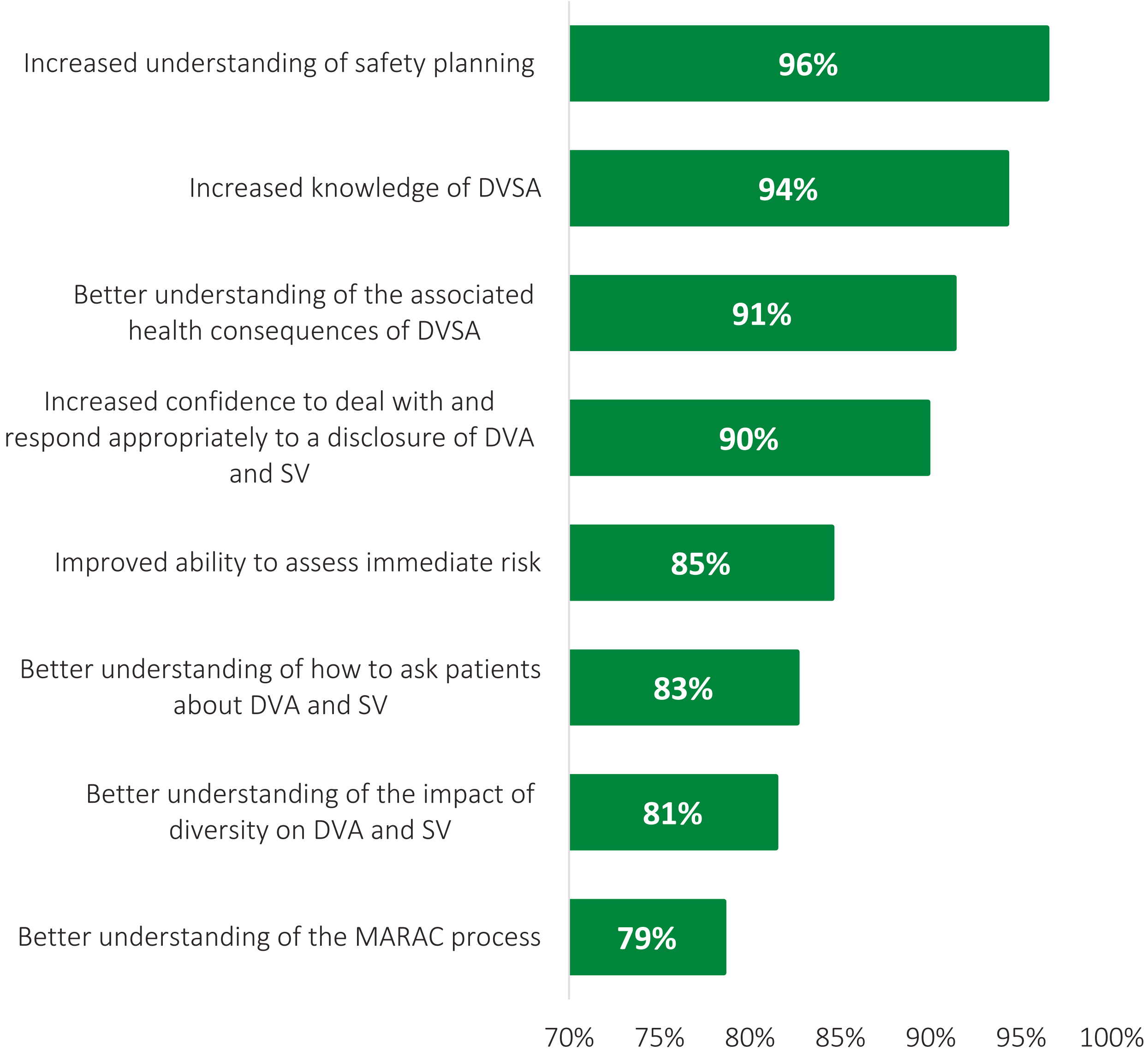
3.2 Outcomes for staff and stakeholders

As outlined in the method section, staff sentiments are from 69 training feedback forms collected by staff, alongside seven interviews with clinical staff and providers. Thus, findings may not be representative of the whole cohort.

3.2.1 Identification and awareness of DVA / SV

Feedback scores from training sessions indicate that the training has been informative for clinical staff and has supported their ability to better identify patients and understand their needs. Notable improvements to knowledge were observed in knowledge of domestic homicide and non-fatal strangulation.

Figure 4.1: Training outcomes for staff



Source: VRU monitoring data, N=82

Training and the provision of on hand staff in the form of an AE has been seen to improve professional curiosity through greater exposure to discussions around the topic and wider understanding of context, for example with 81% of respondents indicating improvement in their understanding of the impact diversity has on DVA and SV. This indicates a deeper comprehension of the multifaceted nature of DVA and SV and suggests that staff are retaining learning around cultural sensitivity, which is necessary to fulfil the pilot aim of ensuring the service is accessible to patients of all backgrounds.

> "(My) professional curiosity has been bolstered by knowing how to ask about disclosure and how to act on it." **Delivery staff**
>
> "[I] would say for us here in the team we had training sessions on things that were new, so the exposure to work we don't normally do has been really beneficial." **Clinical staff member**
>
> "Without this kind of training, I am sure pick up of DV will go down hence why it is important to be done on a regular basis." **Clinical staff member**

Staff interviewed reported that the training had given them greater confidence to ask screening questions regarding experience of abuse, further evidenced by 83% of those providing training feedback reporting increased understanding around how to ask patients about DVA and SV.

Further, as alluded to in the effectiveness of the model section of this report, they felt more able to handle the sensitive information given back by patients than they had been able to previously. Subsequently, staff were confident that as a result of the training, patients were being referred to support that may not have been previously.

Whilst all staff said they would ask questions around abuse to patients prior to the training; they reported that previously they would feel more nervous to ask them and be concerned about the answer they would get back and how they could respond to it. This is evidenced in training feedback, whereby 90% of staff reported increased confidence to deal and respond appropriately with disclosures, with an average score of 6/10 prior to training and 8/10 afterwards.

Whilst not possible to evidence through the data as wider statistics regarding MARAC referrals are not available, providers anecdotally noted that they have seen increases in MARAC referrals. This may be due to the reported improved understanding of the MARAC referral process (reported by 79% of responding staff) and increased ability to respond to and safely manage risk (reported by 85% of responding staff). These improvements suggest a greater capacity to intervene effectively and refer to tailored support to ensure patient security in the present and in the future.

3.2.2 Understanding of patient needs

Engagement with training has demonstrated progression towards the VRU's wider aims around violence reduction, by giving delivery staff the knowledge and the tools to identify potential individuals requiring support. Notably, 96% of staff reported increased understanding of safety planning, with scores increasing from 5/10 to 8/10 as a result of training. Interviewed staff discussed how both the training and engagement with the AE had given them more information regarding the nuance of different situations relating to violence and key identifiers and risk factors to look out for.

Staff reported in interviews that both training sessions helped them to feel more able to determine the support needs of a patient. This has been supported by increases in understanding of the health impacts related to these experiences (reported by 91% of staff), as well as increased awareness of the link between DVA and safeguarding (reported by 68% of staff).

> "A real positive is (having) a better understanding of these issues, and understanding the medical interventions needed like MRI etc." **Clinical staff member**
>
> "You can see how the training has been taken on board. It has a positive impact on practitioners and (teaches them) how to utilise pathways confidently, but also to understand the association between sexual health and DA and to have the confidence to ask the question." **Delivery staff member**

Importantly, staff again acknowledged the value of having someone on hand in supporting the understanding of patient needs, supporting continued momentum for referrals. This proactive approach can be seen as a safety net for those patients that may not be at clear risk of immediate harm but may be showing indicators of risk. Therefore, contributing to the better identification of patients.

3.2.3 Building capacity

Staff interviewed commonly reiterated that a key benefit of having the AE in post was increased capacity across the clinical team. Prior to the programme, safeguarding staff were responsible for referrals. As mentioned, with a referral pathway into the AE, clinical staff have been able to focus their capacity on providing clinical support to patients. Importantly, this affords better opportunity to deliver holistic, sustainable violence reduction solutions as per the aims of the programme, subsequently better supporting individuals at risk of harm.

Safeguarding staff also referred to the programme's lasting impacts, including heightened understanding around DVA and SVA, and the recognition of the need for continued learning and specialised training. This may result in improved capacity for the safeguarding team in the longer-term, with staff feeling more confident to engage in discussions with patients and to navigate referral and support pathways.

> "It's taken a workload off us…having someone in place to refer to helps us a lot to focus more on sexual health. This helps us to refocus." **Clinical staff member**

3.2.4 Shared learning and information sharing

Throughout the lifetime of the programme, staff commonly discussed the positive contribution the programme was having to multi-disciplinary working, contributing to improved relationships that will withstand after programme completion. For example, AEs commonly attended safeguarding meetings and operational groups, supporting better management of risk and opening up networks that can be utilised to support patients. This alongside ongoing updates of patient journeys has contributed to greater awareness of patient circumstance, as well as support services.

> "(It's) the value of having a seamless pipeline of support which is more consistent. It's unique as it's looking more holistically not just silo-ing them and their problem into casework. (It's a) cooperative and conducive environment." **Clinical staff member**
>
> "There has been a massive increase in communication between us all, which is such a positive step." **Delivery staff member**

The proactive and supportive nature of clinical leads has positively contributed to the success of delivery, improving awareness across clinics and looking at methods in which to embed delivery moving forward. Having consistent staff dedicated to the programme has been seen as especially important given the turnover of clinical staff, thus increasing the importance of ongoing shared learning and provision of training.

Some staff members explained that they have been able to share resources more widely than within internal teams, which were not available to them previously, subsequently improving the knowledge of local service provision to other staff engaged with patients such as social workers and housing officers. Such findings indicate progress towards wider VRU aims of a community led approach to support.

3.2.5 Identifying referral pathways

Clinical staff were confident that ADViSE support has added value to the existing pathways for patients. It was felt that without the programme, pathways would still be available for patients, but they would be reduced, with longer wait times. Having onsite support provided staff with reassurance that there was someone available who would be able to identify the appropriate support needs for a patient, reducing the burden on clinical staff.

Particularly, the aforementioned improved connection with services, alongside delivery providers offering different provision, has enabled smoother and quicker transition into support services. Being able to refer into the AE who then supports the patient into wider provision has also afforded continuity for the patient, which can be seen as valuable especially when someone may have already been involved with a number of services in their lifetime, and negates the need for repeated disclosures. Further, this will support achievement of better support provision for patients, subsequently improving access to valuable support and better outcomes for patients in the long term.

> "I think there's more connection between services and understanding on our part, so we've been able to work in much closer partnership in engaging people…it's improved the outcomes for our patients (and) there's more communication." **Clinical staff member**

The programme and the provision of the AE has supported the creation of a bank of available pathways of support for patients, with providers expressing confidence that staff understood the value in referrals, even without the presence of the AE.

Staff indicated that they have become more aware of appropriate signposting support, in particular support around specific topics such as FGM and coercive control. It was also reflected that learning around specific forms of abuse had been integrated into staff training as the programme developed, encouraging the development of a sustainable knowledge base amongst clinical staff that can be shared amongst colleagues. This is important as previously it was felt that those not requiring immediate support for crisis situations may not be identified owing to limited support offers, underscoring contributions towards better identifying and supporting patients at risk.

> "They understood (that) this was a shift in their awareness, not just a programme that comes and goes. (Its) absolutely clear that staff understanding has increased around support pathways." **Delivery provider**

One issue with referrals is that for Westminster particularly, given its central location, patients come from outside of the borough often, necessitating knowledge of support offers that are wider than the immediate locality. This may limit the ability to engage in support and highlights the importance of ongoing external capacity, with AE's reporting that they consistently informed clinical staff of available pathways whilst advocating for their use.

3.3 Sustainability

As discussed throughout this report, staff within clinics reported significant learning across the lifetime of the programme and were confident that this knowledge would be sustained and inform future engagements with patients. With training delivered by specialists from the Violence Against Women and Girls sector, topics were relevant and in line with the ongoing changes to the landscape of domestic and sexual abuse. Considering this as well as the changeable nature of staff within the clinics, a consistent approach to ongoing training delivery was a key strength of ADViSE delivery. Those involved expressed concern that the longevity of learning may be limited without this approach.

Despite efforts of clinical teams to advocate for sustainability, limitations around funding have meant that service provision has come to an end with the completion of the pilot. This loss of support was concerning for many involved with the delivery, as there is limited capacity within internal teams to provide comparable support to patients, however delivery has highlighted the value of such support.

The identification of patients at risk has improved as a result of ADViSE, and delivery had become intrinsic to the service within clinics, as it provided patients with access to reactive, multi-faceted support. As discussed within the report, improved relationships have been built between clinics and external providers, supported by improved awareness of service offer. Whilst staff expressed confidence that these relationships will remain, the ADViSE service was explained as a great loss as the level of support available will be limited. Signposting identified patients will revert back to external delivery provision, meaning potentially longer wait times and no physical presence within the clinic. Further, external provision was explained by some to often be based on need and therefore focused on high-risk cases. Consequently, those deemed at less immediate risk may fall through the gaps, and thus not receive support for the abuse, contributing to long-term abuse.

> "In sexual health settings, disclosure of abuse happens in real time, in moments of trust and vulnerability. Without immediate specialist support, those moments are lost - and so are survivors." **Clinical staff member**

A significant amount of discussion has taken place amongst delivery providers and clinical leads regarding the sustainability of the programme, having identified early in delivery that such provision should be funded sustainably by local commissioners, beyond the pilot funded by London's Violence Reduction Unit.

The pilot was additionally showcased at the 2024 BASHH Conference, highlighting its contributions to improving the care of patients experiencing DVA and SVA in sexual health settings. A funding proposal was developed by clinical leads and delivery providers and shared with local authority partners in Westminster. Whilst there was willing from Integrated Care Boards (ICBs) to support the provision, and an understanding of its need, this did not result in additional funding.

The VRU also supported in raising awareness of the importance of sustainability, and developed an evidence base for why this provision should see greater investment from health, indicating the prevalence and cost of domestic abuse within the healthcare system, the vital role in clinicians in identifying those affected by domestic abuse, and the importance of the healthcare system in prevention and early intervention of violence. This included the need for longer term programming, as there are associated risks with programme set up, as experienced with this delivery, regarding mobilisation. The findings were shared with ICBs, local authority leads and other healthcare professionals.

At the time of writing, notification had been given that NHS England would be abolished adding to greater insecurity regarding the future of funding to ICBs and local authorities. There was recognition that this model of delivery is expensive to run owing to the in-depth support needs and professional skills required, as well as a want to deliver equitable support across the whole of London. Subsequently, no funding has been secured.

4. Conclusions and recommendations

4.1 Conclusions

Overall, there is evidence that the ADViSE programme is contributing towards developing a multi-agency, holistic approach to violence reduction, specifically domestic abuse, through better access to earlier intervention.

The programme has surpassed engagement targets across the lifetime of delivery, with 192 initial engagements with patients and 163 successful referrals across both sites in total, exceeding the overall target of 110 engagements across both sites.

The programme has exceeded the expectations of both staff and patients, demonstrating strong and consistent engagement from both clinical and non-clinical staff, as well as patients across both sites. Despite challenges faced regarding recruitment and delivery, the commitment of delivery partners and clinical leads helped maintain consistent support, minimising disruption to patient care. This has been supported by the on-site presence of the AE, which was seen as a pivotal asset in enhancing patient support and staff capability, and adding tangible value by expediting referrals and reducing wait times for vital support, supported by improved multi-agency working.

Training delivered as part of the ADViSE programme has been a particularly impactful element of the pilot, with measurable improvements of staff understanding and confidence in responding to domestic violence and abuse and sexual violence. Staff reported increased professional curiosity and awareness of cultural sensitivities, such as asking relevant questions in appropriate ways and flagging small risk factors.

It has empowered staff to ask sensitive questions but also improved their ability to manage disclosures, subsequently contributing towards higher numbers of patients being identified as at risk. Reducing the vulnerable status of patients through better identification and support demonstrates progress towards the prevention of future violence by reducing the instance of opportunities for violence to take place.

The programme has engaged those that previously had not accessed support for their experiences with abuse, supporting the aim of increased support, particularly for underserved groups. It has served as an important initial access point, helping individuals with their immediate needs whilst supporting them to navigate broader systems of care. Patients consistently reported high levels of satisfaction, noting improvements in mental health, emotional resilience, and overall quality of life.

The consistent presence and oversight of AEs played a crucial role in making patients feel heard and validated, underscoring the importance of programmes of this kind having dedicated, specialist delivery staff.

ADViSE has played a vital role in providing a holistic, patient-centred intervention with far-reaching benefits beyond immediate support needs. Further, the support has helped foster trust and build optimism for the future, with many patients also accessing wider support services they might not have otherwise engaged with.

Further, it has had a ripple effect, strengthening family and social relationships and contributing to more secure and communicative home environments. This evidences contributions towards the legacy of the programme, improving the quality of life for patients.

> “You called me at the perfect time, I’m able to talk to you when previously I held everything in, which was bad for my mental health. I've found this service to be even better than mental health services, you check up without being intrusive.” **Patient**

To summarise, ADViSE has created meaningful, lasting and measurable improvements for both staff and patients engaged with the programme, through improved knowledge, understanding and confidence.

The availability of dedicated, specialist support was seen as vital in improving the lives of patients and ensuring learning amongst staff is utilised and relevant. Delivery has actively contributed to overall VRU aims of better understanding and response to abuse and safeguarding amongst patients, whilst also improving awareness of the support offer. Despite clear improvements in identifying and supporting patients at risk, funding limitations have led to the pilot’s end. It is hoped that the strong partnerships between clinics and external providers will continue, but maintaining timely, holistic support will be limited within the existing capacity of the clinics.

4.2 Recommendations

Based on the available evidence indicating the success of the pilot, the overarching recommendation would be to continue the delivery of ADViSE in sexual health clinics as a critical reachable moment for those experiencing domestic abuse and sexual violence, with delivery maintaining fidelity to the existing model.

We would make the following recommendations for any future delivery of the ADViSE model:

Opportunities for embedding key components of the model into standard practice

- Delivery teams should increase promotional activity for patients, for example, listing provision on clinic websites and displaying information or good news stories such as captured case studies to encourage engagement. This would increase awareness of the service and encourage wider 'word-of-mouth' promotion for all patients attending the clinics, which could in turn support better identification of those at risk of DVA/SVA.
- Commissioners and delivery teams should embed capacity for advocate educators with specialist knowledge of the VAWG sector into safeguarding teams within clinics. This would enable continued on-site presence which was seen as key to the success of models such as this, whilst also solidifying the relationships between specialist organisations and the health sector.
- Delivery teams should embed elements of ADViSE training provision into ongoing staff training within the clinic. Namely, a localised focus on SVA and DVA and how to support within a sexual health setting. At minimum, consult specialists from the VAWG sector when designing training around DVA and SVA to support ongoing knowledge sharing. By harnessing the specialist knowledge of the VAWG sector, it ensures the content of the training is focussing on the key areas, whilst also ensuring this is relevant and current to the needs of those experiencing DVA and/or SVA.

Contributing to a multi-agency approach to tackling domestic abuse and sexual violence

- Delivery teams and wider stakeholders should formalise an ongoing relationship with external providers to ensure patients have access to clear pathways into wider support, and to encourage continued discussions that strengthen multi-agency working. The interactivity and strengthened multi-agency relationships was a key aspect of the service that enabled better support for patients.
- Commissioners and public health leads should consider the role the health sector can play in supporting and funding effective delivery models that strengthen pathways of support for those experiencing DVA and SVA, to encourage long-term, sustainable interventions within sexual health settings.

Improving data sharing and recording

- Delivery teams and commissioners should identify opportunities to streamline monitoring data to improve the quality of data monitoring. Namely, aligning clinic databases with internal provider databases, to mitigate the burden of data reporting and support accurate recording.
- Commissioners should model monitoring data on available reporting through existing databases, to further support accurate reporting.

Annex A: ADViSE Logic Model

	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACTS/ GOALS
LOCAL FUNDERS/ COMMISSIONERS (E.G. LA)	• Financial support, including protected funding for key roles (AE + CL). • Planning.	• Commissioning of service • Participation in overseeing service delivery. • Localisation of medical record prompt. • Engaging CL	• Contract with, and sustained funding for, ADViSE partner to deliver local ADViSE service.	• Delivering DSVA support in line with national guidance. • Better connections with DSVA services.	• Real progress towards local/regional strategic aims around DSVA, beyond a tick-box exercise. • Progress towards a more whole health systems approach.
ADVISE PARTNERS *Delivering the service includes: Engaging with clinics; Delivering training; Providing care pathways including safeguarding; Offering ongoing consultancy and support to SH clinic staff; Encouraging and accepting referrals.	• Specialist DSVA/VAWG sector knowledge and experience. • Specialist DSVA/VAWG sector networks and working relationships. • Organisational support.	• Securing funding. • Recruiting team - AE/s • Delivering the service*. • Participating in wider IRIS/ADViSE network. • Sharing resources, good practice and learning with other ADViSE partners	• Specialist DSVA advocacy and support brokered for patients. • Emotional and practical DSVA support established. • Ongoing support and consultancy to SH clinic staff provided.	• Team development/ professional development. • Better connections with: Sexual health clinics; Joint ADViSE partners, network and other specialist DSVA/VAWG services; Commissioners.	• Improved interaction between sexual health clinics and DSVA services. • Fulfilling charitable/ organisational objects/ mission.
SEXUAL HEALTH CLINIC TEAMS	• Clinician time and commitment. • Space within clinics • Identification of clinician. champion within each participating clinic.	• Identifying CL • Creating/localizing medical record prompt • Engaging in training. • Engaging in ADViSE service and with patients around DSVA. • Adopting consistent policy for recording disclosures. • Facilitating/encouraging participation by local clinics	• Increased enquiry. • Increased identification. • Increased referrals. • Monitoring and evaluation.	• Improved response to DSVA. • Response in line with national guidance. • Better connections with DSVA services. • Continued professional development for staff.	• Improved interaction between clinics and DSVA services. • Satisfaction of offering holistic care for (often complex) patients affected by DSVA, for whom there was previously a limited response.
VICTIMS AND SURVIVORS OF DSVA (and their children)				• Providing (earlier, expanded) access to support for victims and survivors (and for their children, and for perpetrators), including for those not in contact with support services.	• Reduction in abuse and increased safety. • Improved QoL. • Improvements in health outcomes.

Annex A: Interim phase discussion guides

Patient Discussion Guide

Introduction

1. Please could you explain how you found out about the project?
2. Have you had any support similar to this before? (you can just let us know if you have without giving detail of what the support was)

    a. (If no) Did you know it was available before now?

3. Do you feel there is anything stopping you from getting or making it difficult to get support? E.g. availability (time/freedom), trust, perceived links with police, confidentiality

The support you received

4. Was the process of accessing support clear to you? Did you know what to expect?
5. How would you describe your first interaction with the practitioner about the service?
6. Did you feel listened to and understood during your interactions with the support team?
7. Please could you let me know the kind of things you've had support with?
8. On a scale of 1 to 5, how would you rate the support you received, where 1 is least helpful and 5 is most helpful?
9. Is there anything that would make your support better?

The impact of the support

10. What is the main impact the support has had on you or your life so far?
11. Were there any specific aspects of the support that stood out to you as particularly helpful or effective? Or any specific takeaways?
12. Have you seen or do you expect to see any wider impacts on your family/friends/relationships?
13. Has this support made you feel or think differently about the future? Do you have any particular personal goals in mind moving forward?

Moving forward

14. Do you plan to continue accessing these services moving forward? (referrals etc.) If yes, what type of support would you be looking for?
15. How would you explain your experience to someone who was considering getting similar support? Would you recommend it?
16. Do you feel that anywhere else in the health system would benefit from a similar support offer?
17. Any other comments?

Staff discussion guide

18. As an introduction, could you please outline your roles and responsibilities in connection to the IRISi ADViSE project?

19. Has the program been delivered as expected? i.e. has it been utilised, it is clear?
    a. Once trained, are clinicians offering the service?
    b. How has it been managed?

20. What are the patterns of delivery? (time of day, services required etc)

21. How effectively has it been delivered? Both regarding staff training and patient engagement

22. To what extent has the program been accessed by;
    a. Younger people
    b. Members of the LGBTQ+ community
    c. Men
    d. First-time users
    e. Other

23. How do referrals link with MARAC and DASH referrals?

24. To what extent do referrals result in onward referrals to internal / external services?

25. Has the programme led to increased capacity within the team, or increased partnership working?

26. What do you believe were the main impacts of the program on:

    a. Patients
    b. Clinical staff
    c. Non-clinical staff
    d. Advocate Educators

27. What has been the key learning to date? How has this been implemented?

28. What are the key strengths or challenges of the programme?

29. Do you feel that anywhere else in the health system would benefit from a similar support offer?

30. Any other comments? Or anyone else you feel we should speak to?

Annex B: Final phase discussion guides

Patient survey questionnaire

Q26 Please let us know which clinic you attended (we won't be able to identify you from this):

○ Homerton Hospital, Hackney (Alice) (1)

○ St Mary's Hospital, Westminster (Glodie) (2)

○ Other (3) ____

Q27 How many sessions have you received? if you're not sure, please let us know how many times you've been in contact with ADViSE staff.

____

Q50 Did you receive support within appropriate timescales for you?

○ Yes (1)

○ No (2)

○ Please add any comments (3)

____

Q11 Please could you let me know the kind of things you've had support with through ADViSE?

☐ Emotional support (understanding healthy relationships, mental health, confidence) (1)

☐ Referral to another organisation for support (2)

☐ Practical support including housing and finance (3)

☐ Someone to listen to me (4)

☐ Other (please specify) (5)

____

Q46 To what extent, if at all, would you say the support helped you to get what you wanted or needed? (This could include, as an example, accessing secure housing or counselling etc.)

○ To no extent (1)

○ To some extent (2)

○ To a great extent (3)

○ Not sure / don't know (4)

Q16 Were there any specific aspects of the support that stood out to you as particularly helpful or effective?

____

____

Q14 Is there anything that would make your support better?

____

Q32 Quality of life To what extent would you say that you agree with the following statements: 'As a result of the support...' (If you don't feel a factor is relevant to you, please select 'not applicable')

	To no extent (1)	To some extent (2)	To a great extent (3)	Not sure / don't know (4)	Not applicable (5)
I was able to get secure housing (1)	○	○	○	○	○
I improved my financial situation (2)	○	○	○	○	○
I feel less isolated (3)	○	○	○	○	○
I feel more supported (4)	○	○	○	○	○

Q34 Physical health To what extent would you say that you agree with the following statements: 'As a result of the support...' (If you don't feel a factor is relevant to you, please select 'not applicable')

	To no extent (1)	To some extent (2)	To a great extent (3)	Not sure / don't know (4)	Not applicable (5)
I feel less at risk of physical harm (1)	○	○	○	○	○
I feel in better physical condition (2)	○	○	○	○	○

Q33 Mental health To what extent would you say that you agree with the following statements: 'As a result of the support...' (If you don't feel a factor is relevant to you, please select 'not applicable')

	To no extent (1)	To some extent (2)	To a great extent (3)	Not sure / don't know (4)	Not applicable (5)
I feel less at risk of mental / psychological harm (1)	○	○	○	○	○
I have higher self-esteem (2)	○	○	○	○	○
I feel more confident (3)	○	○	○	○	○
I feel at peace with myself (4)	○	○	○	○	○

Q48 Has the support had any other impacts on your life which haven't been mentioned?

____

____

Q44 To what extent, if at all, would you say you accessing the support has had a positive impact on people you know?

	To no extent (1)	To some extent (2)	To a great extent (3)	Not sure (4)	Not applicable (5)
My parents/guardians (1)	○	○	○	○	○
My siblings (5)	○	○	○	○	○
My friends (2)	○	○	○	○	○
My children (3)	○	○	○	○	○

Q45 If you're comfortable, could you please give details on how the support has positively impacted people you know?

____

Q36 Since your engagement with ADViSE, have you accessed any of the following support? Please tick all that apply.

☐ Sexual health services (1)

☐ NHS / clinical services (2)

☐ Criminal justice services (e.g. police) (3)

☐ Wider support services (e.g. mental health, financial support, housing support) (4)

☐ Other (please specify) (5) ____

☐ I haven't accessed any other support (6)

Q51 Could you please let us know what kind of wider support you accessed?

____

Q37 Would you have accessed these other services if you hadn't been involved with ADViSE?

○ Yes (1)

○ No (2)

○ Not sure (3)

Q18 Has the support through ADViSE made you feel or think differently about the future?

____

Q22 How would you explain your experience to someone who was considering getting similar support?

____

Q24 Do you have any other comments?

____

____

Staff Discussion Guide

1. As an introduction, could you please outline your roles and responsibilities in connection to the IRISi ADViSE programme?
2. Overall, what are your thoughts on how the programme has been managed and delivered?
3. What would you say have been the main impacts of the programme?
4. In your view, how, if at all, has the knowledge and understanding of domestic abuse and related service needs changed amongst hospital staff as a result of the programme?
5. Has this learning led to any changes in responses to safeguarding risks for patients and those seeking support?
6. In your view, has the programme impacted awareness and understanding of referral pathways to domestic abuse support?
    a. Are these pathways utilised?
    b. Are there any patterns in the staff who refer?
7. Who is the programme reaching?
    a. Do you feel that these are the intended recipients?
8. Have you experienced any challenges or identified any barriers with the delivery?
9. To what extent has the programme led to increased communication and learning between services and partners?

   a. (If it has) Has there been any outcomes to date from this increased communication and knowledge sharing?

10. Overall, how, if at all, has the programme contributed to engagement with support for those experiencing domestic abuse?

11. Are there any aspects of the programme that can be sustained moving forward?

12. To your knowledge, has any learning from the programme been embedded into the clinic, or will any be embedded moving forward?

13. Any other comments?

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