Section 14 - Health and Domestic abuse: referrals, GP response, pregnancy, A&E and other health providers

Health and Domestic abuse

The cost of domestic abuse to health services nationwide has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million)[1].

National NICE guidance

Domestic violence and abuse: multi-agency working https://www.nice.org.uk/guidance/ph50 guidance recommends that responses to domestic abuse should be a partnership approach and that all partners in contact with victims, perpetrators and children affected by domestic abuse must understand what domestic abuse is, be trained in domestic abuse and able to take action (e.g. know local processes, risk assess, refer to MARAC, provide early intervention).

The CSEW (2015) shows that victims are in contact with health professionals as a direct impact of the domestic abuse due to the physical health and mental health issues.

- The CSEW (2015) shows that 29% of victims in the last 12 months surveyed had a physical injury and 37% had other effects (mental or emotional problems, stopped trusting people/difficulty in other relationships, tried to kill self and other effect (including becoming pregnant or contracting a disease).
- 37% of victims surveyed reported they had sought medical advice. 84% GP's/Doctor's surgery, 13% Hospital A & E, 28% Specialist mental health or psychiatric services, 2% Other specialist clinic (including family planning and sexual health), 8% Other health services.

A recent domestic homicide review lessons learned report[2] has found that health providers in 2013 had the most recommendations on all DHRs completed in that year. Training was consistently the highest proportion of recommendations for all agencies in all four years of the review. This shows two things - that health services see a high proportion of victim and perpetrators.

Further research suggests victims will access health support services more than the general public:-

- *The prevalence of DVA is substantially higher in a general practice population than that found in the wider population[3].*
- *80% of women in a violent relationship seek help from health services[4], usually general practice, at least once, and this may be their first or only contact with professionals.*

Health services therefore play a significant role in domestic abuse and commissioning reflects this. The contracts with commissioned specialist services have specific targets for referrals from health professional each year, briefings to health service providers (including GP surgeries, A&E and midwifery services and health visitors) are commissioned each year, PLI events are attended to give updates on domestic and sexual abuse and citywide training is commissioned in a range of domestic abuse areas and are available for all professionals including health.

[1] Syvia Walby, The Cost of Domestic Violence: Up-date 2009 http://www.lancs.ac.uk/fass/sociology/profiles/34/
[2] https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned
[3] Hegarty K. *What is intimate partner abuse and how common is it*? in: Roberts G, Hegarty K, Feder G, editors. Intimate partner abuse and health professionals: New approaches to domestic violence. London: Elsevier; 2005 as cited in IRIS: Identification & Referral to Improve Safety Commissioning Pack http://www.irisdomesticviolence.org.uk/iris/uploads/documents/IRIS_CommissioningPack.pdf
[4] Department of Health, *Conference Report: Domestic violence: A health response: working in a wider partnership.* London: Department of Health; 2000 as cited in IRIS: Identification & Referral to Improve Safety Commissioning Pack http://www.irisdomesticviolence.org.uk/iris/uploads/documents/IRIS_CommissioningPack.pdf

Heath referrals to the commissioned services

The high risk and medium and standard risk contracts have four health targets in place. These are for domestic abuse referrals from A&E, General Practice, midwifery and Genitourinary Medicine (GUM). **In 2016/17 it is expected that there will be a total of 350 health referrals into specialist domestic abuse support.** A total of 483 health referrals were received into the support services in 2015/16, and therefore the overall target was achieved. This means out of the 1,544 referred for specialist structured support around one third or 31% of all victims were referred by a health provider, therefore health providers play a significant role in the victim journey.

The table below shows the 2016/17 health targets[5] and contract performance in 2015/16.

Health provider	High risk target	Medium & standard risk target	Total	High risk activity 2015/16	Medium and standard risk activity 2015/16	Total health referral activity
A&E	75	100	175	7	244	251
GP surgeries	15	40	55	7	40	47
Midwifery services	20	80	100	21	145	166
GUM	10	10	20	3	16	19
Total	120	230	350	38	445	483

- The **38** high risk referrals in 2015/16 were significantly under the 120 target, with only 31% made.
- The medium and standard target of **230** referrals was significantly overachieved with 445 referrals in 2015/16 (193%). This is however inflated by over reporting in the midwifery services (see the pregnancy part of this section for more details) and higher than expected A&E referrals (244 compared with the expected 100).

The rest of this section discusses the different health providers, the current position and the current issues.

General Practice (GP)

Research finds that general practice is likely to see a lot of victims with domestic abuse '*there is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five-year period*[6]*. This contrasts starkly with its virtual invisibility within general practice, where in fact the majority of women experiencing DVA and its associated effects are not identified'.*

Prevalence rate of victims in the average GP surgery in Sheffield - it is estimated that between 4% and 8% of patients aged between 16 and 59 years will be a victim of DA in the last 12 months. Therefore when the average practice in Sheffield has around 6,740 patients[7] and around 60% are aged between 16 and 59 years, then the ***'average practice'*** **in Sheffield would have around 240 victims (80 male and 160 female) who have been a victim in the last 12 months.**

[5] The targets have been changed in 2016/17 for midwifery (reduced to 100 total referrals), and increased by 10 for GPs and A&E into the medium and standard risk service. High risk targets remain the same with the exception of midwifery.

[6] Wisner CL et al. *Intimate partner violence against women: do victims cost health plan's more?* Journal of family practice. 1999; 48(6): 439 – 443 Women's National Comm as cited in IRIS: Identification & Referral to Improve Safety Commissioning Pack http://www.irisdomesticviolence.org.uk/iris/uploads/documents/IRIS_CommissioningPack.pdf

[7] http://fingertips.phe.org.uk/profile/general-practice/data#mod,2,pyr,2015,pat,19,par,E38000146,are,-,sid1,2000005,ind1,639-4,sid2,-,ind2,-

Information from the minimum dataset reveals that high risk victims said they visited their GP on average five times per year (but this was much higher for some victims) and for medium and standard risk victims the average number of victims to the GP was seven times per year[8].

The PLI questionnaire asked GPs what number of victims they had seen in the last two weeks[9]. The results find that 49 GPs out of a total of 117 had seen a total of 85 victims in the last two weeks where the patient was experiencing domestic abuse. This is around a fifth of GPs in Sheffield completing the questionnaire. The total victims seeing a GP in the last two weeks ranged between one and 10 victims. In addition 10% of GPs said in the last year they had patients who had revealed they were victims of forced marriage, 5% had disclosures by victims of honour based violence and 48% had seen patients who had disclosed being a victim of sexual abuse.

The GPs were asked to report the observed trends they have noted when working with patients experiencing domestic abuse. They reported that patients presenting were younger, older (often carers struggling) and vulnerable older people being victims, patients were more open to sharing than previously, there was often anxiety, depression, coercive behaviour and alcohol all seem to be increasing factors (especially in partner/perpetrator), several healthy patients with unexplained medical conditions disclosing domestic abuse and drugs misuse.

Domestic abuse victims presenting in general practice presents a number of challenges for the GP.

Respondents raised the following:-

- Supporting patients who are experiencing domestic abuse is time consuming; this was raised by a considerable number of GPs.
- The conflict of interest and the challenges that having the perpetrator and the victim on the patient list and the challenge of working with the victim when the perpetrator attends the appointment with the victim.
- The support services are not available to contact or signpost patients to when attending weekend or out of hours surgeries.
- The difficulties when the patient doesn't want help and you don't want to betray their confidence/ patient confidentiality.
- Maintaining the trust of patient when working with safeguarding services.

The information above shows that GPs are frequently in contact with victims of domestic (and sexual) abuse, the current trends observed and the challenging that working with victims of domestic abuse bring to general practice in Sheffield.

Around three quarters of those responding (73%) said they were very confident or OK when supporting patients experiencing any form of domestic abuse whilst 26% said they were not very confident. Similar proportions were observed in the number who felt they knew a lot or enough to advise and refer (77%), whilst 23% felt they did not know much.

Of the GPs who said they did not know much about the domestic abuse support services available in Sheffield and those who did not feel confident when working with victims of domestic abuse a small proportion reported seeing up to 10 victims in the last two weeks. Therefore there is a continued need for training to general practice to raise greater awareness of domestic abuse, explore how to work with those affected by the abuse effectively and about the pathways of referral in Sheffield.

There is also a need to review the training, to attempt to address some of the challenges GPs face over safeguarding, the perpetrator and victim attending the appointment together and confidentiality.

[8] Minimum dataset, 2015/16

[9] The GP PLI questionnaire was written by Louise Potter (SCC) in Liaison with Sheffield CCG, Amy Lambert and Rachel Weldon. The questionnaire (see Appendix 7) was completed by 117 GPs. 78 GPs chose to share the name of the practice they worked for and together they worked in 40 practices. This reveals that at least 40 practices are represented in these results that cited which practice they worked in, but it is highly likely that over 50 were represented.

Action - There is a continued need for training in general practice to raise greater awareness of domestic abuse, explore how clinicians effectively work with those affected by the abuse and about the pathways of referral in Sheffield. There is also a need to review the training, to attempt to address some of the challenges GPs face over safeguarding, working with the whole family, confidentiality and sharing information.

GP practices and Domestic abuse protocols

It is recognised as best practice that each GP practice has a domestic abuse protocol. It should include details on the staff member's responsibilities including how to recognise possible domestic abuse when stress at home is disclosed and how to refer to domestic abuse services. This was an action that came out of a previous DHR-C, when a letter was sent to all practices in 2013 raising their awareness of this issue Of those surveyed in 2016, 81 or 74.3% said their practice did have a protocol and 28 or 25.7% said they did not.

Action – CCG Newsletter to raise awareness of findings from the DA questionnaire completed at the SA PLI, to promote best practice when working with victims, perpetrators and children affected by domestic and sexual abuse; including each practice having a domestic abuse protocol in place.

Specialist domestic abuse training to general practice in Sheffield

The questionnaire wanted to gauge what proportion of practices had been trained in domestic abuse recently (in the last two years) and their current understanding of the current pathways into domestic abuse support here in Sheffield.

- 8% of the GPs surveyed had completed the RCGP Domestic abuse training[10] (the RCGP Violence Against Women and Children online e-learning course which enables GPs and primary care professionals to improve their recognition of and response to patients suffering from any form of domestic abuse).
- In the last two years around the majority (69%) had either both the half GPs and their practice nurses had received specific domestic abuse training (47%), the GP had received training (19%) and the practice nurses only (4%) had. This is extremely encouraging, but it does however mean that 30% of respondents were in a practice where they or their practice nurse had not yet received specific training on domestic abuse in the last two years.
- 88% of GPs said that the practice had received safeguarding training; the GPs and their practice nurses had received specific domestic abuse training (58%), the GP had received training (23%) and the practice nurses only (7%) had.
- The majority (91%) but not all understood that coercion was a form of domestic abuse.

To address this here in Sheffield there is a specific role commissioned to work with health providers, including General Practice. The DASH assessor offers a practice a 30 minute to one-hour briefing, *'domestic abuse awareness, how to identify and where to refer in Sheffield'*. The aim is to increase GP confidence when presented with a domestic abuse victim and increase their awareness of what to do following disclosure. The overall outcome measure is to continue to increase the number of GP referrals into support services. In the last 18 months:-

- 27 practices have been trained or briefed by the DASH risk assessor[11]. Briefings have taken place in practices open to the offer
- 43% of GPs surveyed said that their practice had received a domestic abuse briefing training in the last two years; 36% of cases the GPs and their practice nurses had received specific domestic abuse training, the GP had received the briefing (3%) and the practice nurses only (5%) had.

[10] http://www.rcgp.org.uk/clinical-and-research/clinical-resources/domestic-violence.aspx
[11] Action PMF 2015/6 and 2016/17

The commissioning aim is that during the course of the contract (October 2015 to September 2018) the majority of GP practices will have accepted the briefing offer and will have been briefed.

Action – Aim to provide a DASH risk assessor briefing to all general practices in Sheffield by October 2018. Using the GP questionnaire data to focus on practices with GPs who have shared a high known need (practice has disclosed a high number of victims presenting in the last two weeks) and those who stated their knowledge of the pathways and/or confidence of working with victims is low.

General practices' awareness of specialist domestic abuse support pathways in Sheffield

The questionnaire goes some way to understanding the current awareness of GPs in Sheffield to the domestic abuse referral pathways.

- The majority (87%) were aware of the referral pathways in Sheffield including the MARAC process
- 62% were aware of the IDVAs and the support they offered in the MARAC process.
- The majority (93%) knew there was a citywide helpline available for advice to victims and professional and 85% actively give out the number to patients where relevant.
- 88% have domestic abuse posters and leaflets in their waiting room, 80% have cards containing the helpline details for patients to pick up and 76% had posters in the public toilets in the surgery that contained the helpline number to rip off and take away.
- 72% were aware of the DACT website and understood it as a place to find out information on domestic abuse in Sheffield.

General practice referrals into specialist domestic abuse support services

Half of the GPs surveyed (51%) said they had referred into domestic abuse support using the referral pathways.

The commissioned specialist domestic abuse services each have a target for GP referrals into their service. If the targets were achieved then GP referrals per annum would be a total of 15 high risk and 40 medium and standard risk referrals in 2016/17.

Reported activity finds that the medium and standard risk target has been achieved in the last two years (until October 2015 the target was 30 but it was increased to 40 in the new contract). There were over 40 referrals in 2015/16 and the current 2016/17 performance suggesting the same performance to be expected in this financial year.

High risk referrals do show a different picture, with the target of 15 underachieved in the last two financial years (five in 2014/15 and seven in 2015/16) but in 2016/17 there has been a turnaround in the first two reported quarters of 2016/17.

The high risk services have received 13 referrals from GPs and therefore for the first time in three years, it is highly likely that the high risk GP referral target will be achieved. This is encouraging, as it may suggest more GP are confident into referring to MARAC (the questionnaire shows that the majority know about MARAC) and that more disclosures to GPs are being made (feedback from the GPs that more victims are willing to share).

It is highly likely that GP referrals into the commissioned services will continue to increase as more practices are briefed, as more patients are open to share their situation and if the barriers identified by GPs can be addressed (time to refer, perpetrator present, perpetrator also a patient).

Action – Continue to monitor GP referrals to commissioned specialist domestic abuse support and annually review the target, revising based on the latest two years performance.

Action – Review which practices are referring into support and compare the area of the practice location to police incidents. Identify which practices may need specific domestic abuse training, based on their location and their volume of referrals into support.

The IRIS model – the VAWG strategy is about collaboration and early identification.

The national VAWG strategy supports the IRIS model in GP Practices[12]. The IRIS model is a specialist DA worker located centrally but working into 25 general practices. They hold two training sessions, working with the clinical lead of each practice to deliver these. They train the whole practice work force, including reception staff and receive feedback on their levels of confidence. Each practice has an IRIS lead and is the point of contact between the DA specialist and the practice. The clinical systems EMIS[13] and synergy have HARKS (Humiliate, Afraid, Rape, Kick and Safety) – an add on template that prompts GPs to ask about DA (based on health symptoms presented), puts a 'flagging system noting HARK+ on the patient record when there is a positive disclosure of DVA and is a 'safety tool instructing clinicians to assess immediate risk'. The IRIS DA worker promotes the use of HARKS within the practice and each quarter outcome activity is monitored and discussed between the DA lead and the practice IRIS lead.

IRIS is currently operating in 33 areas. A 12-month pilot outcome report reveals that 220 professionals and 150 reception / support staff were trained and this resulted in 250 referrals to support (a ratio of just over one referral per professional trained). A further benefit of the system raised in a recent Joint Targeted Area Inspection (JTAI) on children affected by Domestic abuse completed in Salford[14] found that GPs involved in the IRIS project routinely considered the child's wellbeing by *'contributing routinely to initial health assessments, including information on children's emotional health and well-being when a child becomes looked after, thus enabling a better of understanding of their needs'.* – See Part 3 - Children and Young People for more information on children affected by Domestic abuse.

The VAWG strategy states it will promote the model to commissioners during 2016/17. The model does however present additional costs (estimated £65,000 to set up) to the city. In Sheffield the additional costs of the IRIS model need to be weighed up against the current DASH risk assessor offer, which is unique to Sheffield and appears to be having some impact in General Practice at raising awareness (GP questionnaire) and referrals against the more intense, IRIS offer which (as the evidence suggests) is likely to have greater impact (more referrals).

CCG and routine enquiry in general practice

The CCG are currently exploring a pilot initiative to roll out domestic abuse routine enquiry to patients in some practices across Sheffield. This is not currently done locally; however recent pilots in Leeds have had success. Research by Westmarland et al (2004)[15] provides some insight into the benefits of routine enquiry in general practice. The pilot had three north of England GP practices trained in

[12] VAWG Strategy 2016-2020, page 21 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF

[13] EMIS is one clinical system in general practice used by a significant number of practices in Sheffield,

[14] https://www.gov.uk/government/publications/joint-inspections-of-the-response-to-children-living-with-domestic-abuse-september-2016-to-march-2017

[15] Westmarland, N., Hester, M., Reid, P. (2004) *Routine Enquiry about Domestic Violence in General Practices: a Pilot Project*

domestic and sexual abuse and then implemented routine enquiry for a three month period[16]). The outcome was that 9% of patients asked disclosed a current or history of domestic abuse. This is 9% of victims who would perhaps have not shared their domestic abuse at that current time had the routine question not being asked. Interestingly, it is a similar percentage to the 8% prevalence that women have experienced violence in the last 12 months (CSEW 2015).

Westmarland et al (2004) found that the majority of patients did not mind being asked (*73% of women and 75% of men thought it would be helpful to ask all patients about domestic violence).* The GPs involved in the pilot varied in their knowledge and experience of domestic abuse and the majority were aware of the health impacts of domestic abuse on victims. Concerns raised by GPs prior to the pilot included lack of awareness of the domestic abuse specialist offer, being too intrusive and negative responses by patients. GP feedback after the pilot scheme was on the whole positive, having greater confidence in asking patients about domestic abuse, the pilot raised the profile of domestic abuse in the surgery waiting area and patients were generally positive about being asked. Some issues remained including limitations on consultation time with the patient following a disclosure and remembering to ask. The opportunity to have a pilot scheme in Sheffield is encouraging and opportune at a time when the national strategy is promoting the benefits of early intervention and funding the *Change that lasts* initiative that focuses on building up the trusted professional awareness and response to VAWG.

Action – Review the benefits of the IRIS model and/or routine enquiry compared to the current DASH risk assessor offer for Sheffield and if the decision is made for the IRIS model, then work is required with the CCG to consider how the IRIS model could be funded and operate in Sheffield. Both the IRIS model or the routine enquiry model would require identifying a number of key general practices in Sheffield to work with (in practices where it is known DA has been identified, GPs have received some training and practices are in locations where there are a high number of reported domestic abuse police incidents compared to the citywide average).

Pregnancy

Pregnancy is known to be a vulnerable time for women. McWilliams and McKiernan 1993 found that in 30% of cases, pregnancy was when domestic abuse started in a relationship[17]. The NHS also reports that existing abuse may get worse during pregnancy or after giving birth[18].

Johnson et al (2003) completed a study of pregnant women presenting at maternity services in Hull. Around 500 responded to the questionnaire on domestic abuse. The study found that Domestic violence was highest in those who were pregnant and in the age group 26–30 years and boyfriends were the main perpetrators. Punching and slapping were the most common pattern of violence, and 10% of women experiencing domestic violence had had forced sexual activity. Brownridge et al (2011)[19] in an American Study found similar findings to Johnson et al (2003) on the nature of the abuse, those who had domestic abuse during pregnancy were more likely to experience all forms of violence; threatened, pushed, slapped, hit with something that could hurt, choked, sexually assaulted, beaten up, kicked, bit, and hit with the fist.

There is a wealth of research that reviews the negative impacts on domestic abuse during pregnancy. For example studies find that violence during pregnancy can lead to an increased risk of miscarriage, premature birth, low birth-weight, foetal injury and even foetal death (Stark et al, 1979; Bohn 1990; Webster et al, 1996, Coker et al, 2004[20])

[16] The research found that one of the three practices had greater impact at rolling out the routine enquiry, the GPs who attended both training days were more likely to ask routinely during the project and some GPs selected who to ask.
[17] DoH, 2004; as cited in RCM Domestic abuse
[18] http://www.nhs.uk/conditions/pregnancy-and-baby/pages/domestic-abuse-pregnant.aspx
[19] Brownridge, Douglas A.; Tallieu, Tamara L.; Tyler, Kimberly A.; Tiwari, Agnes; Chan, Ko Ling; and Santos, Susy C., "Pregnancy and Intimate Partner Violence: Risk Factors, Severity, and Health Effects" (2011). *Sociology Department, Faculty Publications.* Paper 154. http://digitalcommons.unl.edu/sociologyfacpub/154
[20] http://www.nhs.uk/conditions/pregnancy-and-baby/pages/domestic-abuse-pregnant.aspx

The estimated number of women who are pregnant and likely to be a victim of domestic abuse is complex to ascertain. The prevalence estimates for the number of women affected by domestic abuse whilst pregnant for Sheffield are based on:-

- The CSEW estimates (8.2% of women will be a victim of domestic abuse in the latest 12 month period)
- A search of the internet has found a varied prevalence rate in research on pregnancy and domestic abuse, suggesting domestic abuse is present in between 7%[21] and 17%[22] of all pregnancies, it should be noted, though the nature of the 17% was not universal screening. Taft (2002) found between 4 and 9 women in every 100 are abused during their pregnancies and/or after the birth[23], 14.7%[24], 11.3% of victims experienced domestic abuse while pregnant[25]
- Refuge cites that *'One midwife in five knows that at least one of her expectant mothers is a victim of domestic violence'*[26] *and 'A further one in five midwives sees at least one woman a week who she suspects is a victim of domestic violence'*

The estimated prevalence of pregnant women affected by domestic abuse (per annum)

In 2014 there were 6,575 live births in Sheffield (ONS)[27]. The ONS statistics for 2015 births is not yet currently available but locally held data suggests there has been an increase in live births to around 7,000 in 2015. Whilst the 6,575 in 2014 is significantly lower than the local 7,000 for 2015, neither figure takes into the total number of pregnant women in Sheffield in any given year, as it is inflated for multiple births (16 in every 1,000, with 98.6% of these births twins) but does not include mothers of still born children (5 per 1,000 births in Yorkshire and Humber or those who miscarry.

Research statistics vary in their estimations on the proportion of pregnancies affected by domestic abuse range (4% and 17% of all pregnancies) and average at 10.2% or one in ten of all pregnancies. The average is probably reasonable if one considers that 8.2% of women in any given year will be affected by domestic abuse, that pregnancy is a time when domestic abuse is more likely to happen to women and that the 17% appears high (based on those completing and returning a questionnaire, which may mean those at risk were more likely to return) and others were based on universal screening and are more likely to provide a more reliable prevalence figure.

For the purposes of this report research findings have been applied to both ONS and local birth activity figures for the number of live births in Sheffield and are found in the table below.

[21] McFarlane et al, 1994
[22] J.K. Johnson, F. Haider, K. Ellis, D.M. Hay, S.W. Lindow (2003) The prevalence of domestic violence in pregnant women. *BJOG - An international journal of obstetrics and gynaecology Volume 110, Issue 3 March 2003 Pages 272–275* http://onlinelibrary.wiley.com/doi/10.1046/j.1471-0528.2003.02216.x/full
[23] Taft, 2002
[24] Coker, A, L., Sanderson, M & Dong, B. Partner violence during pregnancy and risk of adverse pregnancy outcomes *Paediatric and Perinatal Epidemiology Volume 18, Issue 4, pages 260–269, July 2004*
[25] Brownridge, Douglas A.; Tallieu, Tamara L.; Tyler, Kimberly A.; Tiwari, Agnes; Chan, Ko Ling; and Santos, Susy C., "Pregnancy and Intimate Partner Violence: Risk Factors, Severity, and Health Effects" (2011). *Sociology Department, Faculty Publications. Paper 154.* http://digitalcommons.unl.edu/sociologyfacpub/154
[26] http://www.refuge.org.uk/get-help-now/what-is-domestic-violence/domestic-violence-and-pregnancy/
[27] ONS Table 2 Live births (numbers and rates): age of mother and administrative area of usual residence, England and Wales, 2014

Prevalence estimate based on research	Estimated pregancies affected by DA in Sheffield per annum	locally held data (2015)	Researcher
Number of live births in Sheffield	6575	**7,000**	
4% of all pregnancies	263	280	Taft (2002), Leeds Maternity Health Needs Assessment (2014)
7% of all pregnancies	460	490	McFarlane et al, 1994
8.20% of all pregnancies	539	574	CSEW, 2016
9% of all pregnancies	592	630	Taft (2002)
11.30% of all pregnancies	743	791	Brownridge et al (2011)
14.70% of all pregnancies	967	1029	Coker et al, 2004
17% of all pregnancies	1118	1190	Johnson et al 2003
Average of all estimates	669	712	

When observing the average (10.2%) of pregnancies to be affected by domestic abuse, it is estimated that between 669 and 712 pregnant individuals are affected by Domestic abuse per annum. If the highest and the lowest prevalence estimates from research are applied (4% and 17% of all pregnancies) then it could be as low as 260 and as high as 1,100 pregnancies that may have some form of domestic abuse.

Number of domestic abuse disclosures to maternity services in Sheffield

Maternity services in Sheffield use universal screening (The Royal College supports routine enquiry of domestic abuse throughout the pregnancy) and routinely ask women about domestic abuse at their first appointment. Midwifery services in Sheffield during 2015/16 had around 350 disclosures[28] (either domestic abuse is information contained on the referral form to the midwife from the health professional or where the victim directly discloses the domestic abuse to the midwife).

Based on the numbers of babies born in Sheffield during 2014, the 350 disclosures suggest there could be around a 5% disclosure rate by pregnant women in Sheffield to their midwife. This is similar to the rate observed by the Leeds Midwifery team, where universal screening approximately identified a 4% disclosure rate in all pregnancies during 2014.

It is estimated that between 31% and 52% of pregnant victims of DA each year are disclosing the abuse to their midwife[29] which is significant and on par if not higher than the proportion (31%) of victims reporting a domestic abuse incident to the police per annum[30]. It does however suggest that a significant proportion remains hidden or is not disclosed to the midwife directly.

Estimated demand for pregnant women and domestic abuse support services

Of the total estimated prevalence for Sheffield, for pregnant and non-pregnant victims (see Section 3), only a small proportion (7%) are in contact with specialist domestic abuse support services, therefore it is likely the same will apply to pregnant women.

If 7% of the estimated pregnant women per annum who are in a victim of domestic abuse (average of 712 but could be as high as 1,110) then 7% would be between 50 and 78 accessing structured support in a given year).

The current number of pregnant women in Domestic abuse support services

Domestic abuse support services have reported data in a number of forms to DACT; together these provide a picture of the number on the caseload, the number of referrals received into their services

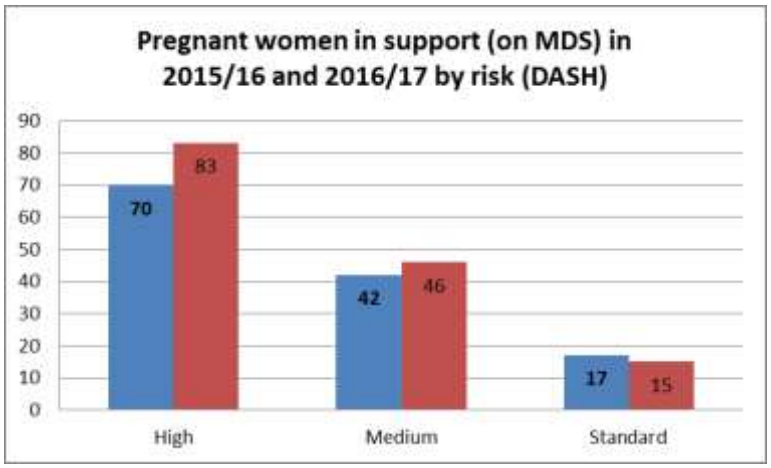
[28] Mirelle Martin, Sheffield Teaching Hospitals. Information from Summer 2015

[29] Based on the average estimated prevalence figure for Sheffield is around 670 pregnant women (but could be as high as 1,100) and 350 disclosures.

[30] 21,000 victims per annum (CSEW) and around 6,600 victims per annum report an incident to the police in 2015 (Lisa Street) which is 31%.

and the source of these referrals.

In 2016/17 the minimum dataset[31] had a total of 144 pregnant females recorded in support with the commissioned high risk and medium/standard risk services and 129 in 2015/16[32]. The majority are recorded as high risk cases (as show in the graph below) accounting for 54% in 2015/16 and 57% in 2016/17.



The data suggests victims who are **pregnant are more likely to be accessing support than victims who are not pregnant.** This is based on the following:-

- If the estimate of 712 victims per year who are pregnant is applied, a potential 20% of pregnant victims accessed structured support in 2016/17,

- If the more conservative figure of 1,100 is applied, a potential 13% of pregnant victims accessed structured support in 2016/17.

- Both estimated are significantly higher than the estimated 7% of all victims who access support.

- Neither estimate accounts for the 471 midwifery contacts with the helpline in 2016/17 (with the assumption made that some of these contacts will be in addition to the 144 in structured support but some will also be duplicate calls to the helpline)

Referrals made by midwifery services into domestic abuse support: -

- Midwifery services make up a significant number of the referrals of pregnant women into support services, but they do not account for all of them.
    - In 2015/16 midwifery services were the second highest referrer of pregnant women into domestic abuse support services, accounting for 19% of high risk referrals of pregnant women and 33% of pregnant women to the medium and standard risk service (local data request).
    - It is estimated that between 50[33],[34] and 85 midwifery referrals were made to commissioned support in 2015/16. *The estimate has been provided because we know that data on midwifery referrals into support services is inflated (Reported PMF activity shows 164 referrals from midwifery services in 2015/16 to domestic abuse support due to known inaccurate reporting[35] for quarter one, which was significantly higher than quarter two to*

[31] Minimum dataset for domestic abuse 2016/17
[32] Minimum dataset for domestic abuse 2015/16
[33] Local data found 16 high risk referrals from midwifery and less than 10 referrals for the quarter for the standard and medium risk service (Action, June 2016).
[34] Estimated applied using three quarter's activity to forecast a year's total.
[35] The total figure included helpline contacts from midwifery as well as formal referrals. The two cannot currently be separated.

quarter four).

Other referrals of pregnant women into support services (source – local data request)

- Referrals of pregnant women into domestic abuse support services come from a variety of referrers including Police, Housing, adult and children's social care, probation and A&E: -
    - 74 referrals into High risk service are from 14 different referral sources (12-month period)[36]
    - 18 referrals into medium and standard risk (in a three-month period) from seven different referrers (this is estimated to be around 36-40 over a 12 month period)
- The highest referrer for pregnant women into domestic abuse support is the police, accounting for 48% of high risk and 38% of medium and standard risk pregnancy referrals.

Midwifery contacts with the helpline

- Midwifery services[37] have explained that often the helpline is contacted on cases where there has been a DA incident and they have then been notified. The contact with the helpline does not automatically mean the victim is then referred into commissioned support.
- The individual midwifery contacts with the helpline was 229 in 2015/16 (data source: PMF), however this has increased significantly in 2016/17 to 471 in 2016/17.
- NOTE - There will be some overlap between helpline contacts and referrals

What we don't know exactly

- The number referred by a midwife but did not go onto the caseload.
- The number who did not consent to using their data for analysis, and are therefore not counted in the figures.
- Activity on victims who are only subject to sexual abuse during pregnancy.
- The total number of victims who are pregnant

Midwifery services[38] have completed a service evaluation and have proposed that on their Jessops Maternity Information System (JMIS) is developed so that DA data is collected and reported.

Action – Improved data quality of midwifery data is required of commissioned services (referrals into the service) and the development of the JMIS for midwifery data recording.

The target for referrals from midwifery into domestic abuse support

The high risk and medium and standard risk services both have a target specifically for referrals from midwifery services. These targets have remained in place for the last three financial years.

The target for the total midwifery referrals into services is 315 cases, of which 250 (80%) will be standard risk and medium risk cases and 65 (20%) will be high risk cases. The targets were based on pathways at the time, a local QIPP initiative that has since stopped and potentially inflated data[39].

Activity by support services suggests that the target is too high because only 52% of the target was achieved in 2015/16. There are three theories why this is;

(1) Midwifery referrals are at an appropriate level and the target is too high
(2) Midwifery referrals should be higher
(3) That a midwifery referral would not be undertaken if another external agency (e.g. the police) had been already been made and the midwifery service had been alerted

[36] Action, June 2016
[37] Mirelle Martin, STH Midwifery Services Sheffield, May 2017
[38] Mirelle Martin, STH Midwifery Services Sheffield, May 2017
[39] The effectiveness of the QIPP and the old pathways were measured using the case management system Paloma Modus. Workers logged onto the system using a maternity log on, for maternity service users and used another log on for all others on the caseload. It has since come to light there were data processing issues, meaning the data used at the time to calculate the targets, is likely to have been inflated by an incorrect logging of activity due to workers using the wrong log on. The unknown is the extent to which this may have happened.

The data in this needs assessment finds that;

- Referrals of pregnant women into support are not just from midwifery services
    - Midwifery services[40] explain that they completed routine enquiry on DA as part of their processes. Some women will disclose to them but others may disclose to another service. The thought process around routine enquiry is that for some it is the start of a process which may result in the victim considering disclosure, than they would have previously. However the woman may later disclose to another service.
    - The DASH risk assessment tool includes a question on pregnancy and the DASH is completed by a wide range of services.
    - Midwifery services[41] find that some women do not want to disclose to midwifery services for fear of social care involvement.
- a significant proportion of pregnant women are accessing support,
- disclosures to midwives are on par with another area (Leeds)
- pregnancy engagement with support services is higher than for victims who are not pregnant.

This is not to say that with more disclosures, more referrals would be made and there do remain a significant proportion of pregnant women who do not access support services. But together it does suggest it is highly unlikely that the midwifery referrals target of 315 cases would be achieved.

Revised target recommendation

It has been agreed (between commissioners and midwifery services and the commissioned services and with view of the data) that the referral target will be changed to monitoring the total pregnancy activity within commissioned support, with emphasis on those referred by midwifery. Therefore we will:-

- Monitor - the total number of pregnant women in support
- Monitor – the total referrals to support made by midwifery services
- Monitor – the total midwifery contacts with the helpline.

The MDS data for the last two years shows structured support take up is around 130-140 pregnant victims, therefore the commissioner would expect similar levels in each year. The data in this report will be used as a benchmark, so if pregnancy referrals, engagement and contacts reduce, then swift action can be taken.

Action - Change how commissioners target referrals from midwifery services and engagement of pregnant women in support, and amend the PMFs accordingly.

Action – The DA strategic lead, DASH risk assessor and high risk service training lead to meet with midwives to raise their awareness of the referral process, and discuss how they can work together to increase midwife's confidence in getting disclosures and following a disclosure subsequent consent to refer into support.

Action - Improved data quality of midwifery data is required of commissioned services (referrals into the service) and the development of the JMIS for midwifery data recording

Action – Ensure all referral sources for all pregnant women are monitored, given we now know a significant proportion of the pregnancy referrals are from other referral sources

Domestic abuse support services and pregnant women

[40] Mirelle Martin, STH Midwifery Services Sheffield, May 2017
[41] Mirelle Martin, STH Midwifery Services Sheffield, May 2017

All commissioned services are required to follow the protocol that they will liaise with the Vulnerabilities Specialist Midwifery Team and children's social care to ensure smooth referrals into domestic abuse support and refer all service users who are 16 weeks or more pregnant into the Safeguarding midwives service. This has been reported as been effectively in place with the high risk, the medium and standard risk and the sexual assault support services.

In Sheffield midwives can contact the helpline to ascertain if individuals are known to services – Action reported to DACT in July 2016 that this is working well and that the numbers of requests remain high.

Action – Review the effectiveness of domestic abuse and pregnancy pathways between support services and midwifery services and where required review/ change accordingly.

Midwifery training in domestic abuse pathways and processes in Sheffield

There is a need to ensure that midwives are appropriately trained and briefed in the current domestic abuse processes, pathways, disclosure and referral in Sheffield.

- Midwives receive mandatory training on domestic abuse and have done over the last 2 years[42]
- Domestic abuse training has been included in the competency framework for midwives
- DACT commission two sources of training and advice. These are the DASH risk assessor role in the medium and standard contract and the training contract.

DASH risk assessor support to midwifery services

Part of the DASH Risk assessor role is to work with midwifery services to offer referral advice on specific cases and provide briefing events on identification, disclosure and referrals into support. Latest activity shows that the DASH risk assessor worked with midwifery services on around 50 cases and provided a briefing to community midwives during 2015/16 and the central midwife team in Q1 2016/17.

The number of briefings to midwives appears low compared to those given to A&E staff and whilst the tendering of the contract in 2015/16 may have impacted on this, the same has continued in 2016/17. Indications from midwifery services suggest that poor attendance was as a result of higher clinical priority on the days when these were held.

Training for midwives on domestic abuse

- DACT commission domestic abuse training that is available citywide and can be accessed by the midwifery services. The training is generic and activity is not monitored by specific STH service in 2015/16, so it is difficult to understand the number of midwives accessing the training in this year.
- The contract does not specify the number of training places available for midwives but the contract does offer additional responsive days should specific services require training. These days can be used to offer specific catered training to midwives. In the first three months of 2016/17 two lunchtime training sessions have been offered to midwives but one was not attended and the other was cancelled.

There is some potential overlap (discussed in review meetings with DACT commissioners and service providers of the training contract and the medium and standard contract) between the information given in the DASH risk assessor briefings and the specialist training. It is believed that this may have impacted on the midwives' perceived need to attend both briefings and training sessions alongside the busy workload midwives have. In addition the medium and standard contract was tendered during

[42] Mirelle Martin, STH Midwifery Services Sheffield, May 2017

2015/16[43] which is likely to have also impacted on the relatively low observed take up of either briefings or training by midwives.

The two DACT contracts do not specifically state what proportion of training is offered centrally to midwives working at Jessops Wing at the STH or to those working in the community. One contract has the training element and the second the DASH risk assessor role. These contracts are now held by the same provider which gives an opportunity to offer a more enhanced or alternatively a more streamlined (time saving) offer to midwifery services.

It is not known by DACT what proportion of midwives at Jessop or based in the community have received specialist domestic abuse training in the last year therefore it is unknown what proportion of midwives have received domestic abuse training in the last two or three years.

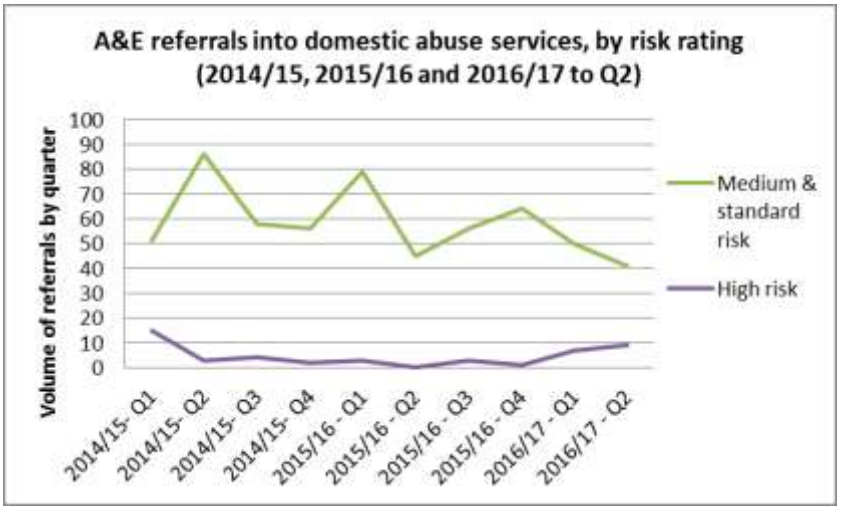
Discussions with midwifery services also indicate that there is also an opportunity to focus further on domestic abuse during midwifery training of student midwives, when it is perceived as an apt time to focus on this area.

Action – Consult with midwives at Jessops and in the community to identify their domestic abuse training and briefing needs in 2016/17, agree the number of midwives to receive training per annum, provide specific domestic abuse training streamlining lunchtime training sessions and briefings, removing any unnecessary overlap and offer as one package and monitor activity.

Action – Midwifery services to approach the University of Sheffield to explore how domestic abuse training can be enhanced, so midwives are aware of the local processes and pathways for working with victims and families affected by domestic abuse.

Accident and Emergency (A&E)

Referrals into high risk Domestic abuse support - The high risk service has a target of receiving 75 referrals per annum from A&E. This target has not been achieved in the last two financial years (2014/15 and 2015/16) when activity was 24 and 7 respectively. Quarterly referrals do fluctuate and has been as high as 15 and as low as 0 during this time period. There had been a decreasing trend since Q1 2014/15 (see Graph XX) but this has changed in 2016/17, with 16 referrals observed by the half year point which is already more than double that observed for the whole of 2015/16. This is encouraging, particularly when one also observed that the 16 are all appropriate referrals.



[43] The Medium and Standard contract was tendered during 2015/16. The new contract was started in October 2015, with a new provider.

Referrals into medium and standard risk Domestic abuse support - The target of 100 A&E referrals into medium and standard risk support was over achieved in 2015/16, with a total of 244 referrals. This is similar to the 251 of the previous year (2014/15). The most recent activity in 2016/17 finds that referrals have dropped a little and this will be observed quarterly as per the performance monitoring process DACT has in place.

Part of the DASH Risk assessor role is to work with A&E to offer referral advice on specific cases and provide briefing events on identification, disclosure and referrals into support. A&E have received nearly 30 briefing in the last 12 months (October 2015 to September 2015[44]), which is encouraging. A&E referral activity of both commissioned services suggests that the briefings are successful at raising the profile of support services to A&E staff and that medium and standard risk victims are accepting the offer of support.

Genito-Unrinary - GUM

Referrals from GUM into support services have been relatively consistent over the last two years. Each service has a target of 10 referrals per annum. Together the services have received 16 referrals, with the majority going to the medium and standard risk service. The activity shows there are processes in place for referrals from GUM to the specialist services. Activity will be monitored quarterly as per the performance monitoring processes and should referrals reduce, further work can be completed with GUM and the DASH assessor and training service.

'Other health' providers and their referrals into support services

All health referrals are monitored quarterly by the commissioned services and reported to DACT, but there are no targets associated with the activity. 'Other health providers' include referrals from mental health services, health visitors and other health services and in the last four quarters together have sent 97 referrals to the two commissioned services. 41% are referred to high risk and 59% to the medium and standard risk service. This is a markedly different ratio to the performance activity of the health services already discussed (GPs, A&E, GUM and midwifery), where the high risk victims referred is significantly lower than the medium and standard risk victims, for example high risk referrals are 15% of all GP DA referrals, A&E is 3% high risk, GUM is 18% high risk and midwifery 13% high risk. This therefore raises the question whether these 'other health' services could and should be referring more victims to the medium and standard risk service and that perhaps workers may be missing the opportunity to discuss specialist support with victims.

- **See section 18 on therapeutic support for more details on mental health and domestic abuse**

Action – Review referrals into support by the wider health services and explore how further opportunities can be given to encourage further use of the DASH and onward referral for medium and standard risk victims of abuse in these services.

The effectiveness of health providers working with those affected by domestic abuse

The needs assessment has focused on the effectiveness of the referral process from health services to specialist support services. The needs assessment does not focus on the effectiveness of health services working with those affected by domestic abuse. This is the remit of the CQC and their auditing processes and each individual service's internal audits on domestic abuse against national NICE guidance.

At present there is no link to communicate the outcome of such audits direct with the Domestic Abuse Strategy Manager; however it would be beneficial for this process to be arranged. This would provide

[44] Action PMF 2015/16 and 2016/17

assurance that victims were not missed, that opportunities to disclose where offered routinely and that safeguarding processes were being followed by health providers in Sheffield.

Action – Health providers to communicate the outcome of any external or internal audits that focus on domestic abuse