Nottinghamshire County Council

Report to the Public Health Sub-Committee

18 July 2013

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

USE OF PUBLIC HEALTH GRANT TO ADDRESS COMMUNITY SAFETY AND VIOLENCE PREVENTION

Purpose of the Report

1. The purpose of this report is to provide a case for Public Health part funding (the remainder being sought from individual Clinical Commissioning Groups) the commissioning of Identification and Referral to Improve Safety (IRIS). £153,000 is sought from the Public Health Grant recurrently.

Information and Advice

Definitions

2. The Home Office (2013) defines domestic violence and abuse (DVA) as:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

3. IRIS is a domestic violence training, support and referral programme for general practice staff. It is a targeted intervention for female patients aged 16 and above who are experiencing or who have experienced domestic violence and abuse from a partner, ex-partner or family member.

Context

4. Domestic abuse is an indicator in Domain 1: Improving the wider determinants of health of the Public Health Outcomes Framework.

5. Domestic violence and abuse has been identified as a priority for action for the Safer Nottinghamshire Board, the Nottinghamshire Health & Wellbeing Strategy and for the recently elected Police and Crime Commissioner. Further to this the Mandate[i] from the government to the NHS England cites the broader role of the NHS in society is to work in

partnership to contribute to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners and supports victims of crime.

6. Following obtaining the support of the Health and Wellbeing Board in January 2013 (appendix 1) Clinical Commissioning Groups have begun to engage in and plan for the implementation of IRIS across general practice. Mansfield and Ashfield CCG have made the most progress and are currently tendering for a service provider.

The Rationale

7. Domestic violence and abuse is common. The majority of DVA incidents or victims remain hidden, i.e. they are not disclosed to authorities. However, it is possible to estimate the numbers of victims by applying the findings of the British Crime Survey 2011/12 to the Nottinghamshire population and this is shown in Table 1.

Table 1: Estimated Number of Female Victims of Domestic Violence in Nottinghamshire (16-59 years of age)[ii]

Period	Percentage	Numbers
Across their lifetime	29 - 32	66,410 and 73,280
In the last year	7 - 11	16,030 and 25,190

8. Whilst DVA occurs across all sections of society, men are far more likely to be the perpetrators and women the victims. Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional impact or result in injury or death[iii]. Consequently DVA causes an inequality in ill health amongst women. Survivors of DVA can have chronic health problems including: gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease[iv]. The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse[v].

The IRIS Service

9. The IRIS service comprises of:
   - *A named Advocate Educator:* linked to the practice and based in a specialist domestic violence and abuse service. The Advocate Educator acts as a consultant to the practice team and is the person to whom patients wanting support are directly referred.

   - *Training and support*: each medical practice receives in-house training and ongoing support. Clinician training focuses on identification of DVA through clinical enquiry and appropriate response, referral and recording. Training for reception and administration teams focuses on understanding DVA, data handling, confidentiality and safety.

   - *Electronic prompt*: This appears in the patient medical record in the form of a pop-up template triggered by read-coded symptoms and conditions associated with DVA. The electronic prompt is a reminder to ask and record data about DVA.

   - *Health education resources*: posters about DVA are put up in practices and cards provided for patients. Practices receive referral forms and care pathways for female survivors, male victims and perpetrators.

- *Named contact for patient referrals* - practice staff can refer directly by phone, fax or email to the Advocate Educator.

- *Advocacy for patients* – an Advocate Educator provides patients with emotional and practical support and carries out risk assessments and safety plans. The Advocate Educator acts as a triage and brokering service, signposting patients into other services as necessary.

Expected Outcomes

10. The IRIS approach aims to increase identification of victims of DVA in primary care and provide primary care practitioners with the skills and tools to respond to, refer on and record disclosures of DVA from their patients.

11. General Practice can play an instrumental role in responding to and preventing further domestic violence. Implementing this approach will lead to:
    - increased case findings
    - improved support available sooner,
    - improved patient safety
    - reduction in recurrence of DVA
    - reduction in safeguarding issues
    - improvement in the quality of care for patients.

12. The IRIS approach has proven to be cost effective and possibly a cost saving intervention in general practice.

Other Options Considered

13. **Maintain the status quo.** This option would not equip practice staff with the skills specified in section 9 nor secure the outcomes identified in section 10 above.

14. **Provide match funding to one CCG or a few practices as a pilot.** The IRIS approach has been subject to a randomised controlled trial following which Nottinghamshire has secured support with local implementation from the national IRIS team (which is not available to all areas pending review of the national team's capacity and resources). Providing IRIS on a smaller scale would be less efficient and would not address the issues to do with equity outline in section 7 and 8.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications related to the NHS constitution (together with any statutory guidance issued by the Secretary of State)

16. Regard has been taken to the NHS Constitution together with all relevant guidance issued by the Secretary of State in formulating the recommendation.

Implications for Service Users

17. Improvement in and consistency of the response from general practice to the identification of and support made available to people experiencing domestic violence and abuse.

Financial Implications

18. Implementation of IRIS across Nottinghamshire has first year costs totalling £313,000. A total of £153,000 recurrent funding is sought from the Public Health grant so as to part fund the intervention. The remaining costs will be funded from the CCGs. Public Health does not currently commit any other finance towards domestic violence prevention and reduction in primary care.

RECOMMENDATION

1. That the Public Health Sub-Committee are asked to:

   Approve £153,000 of Public Health Funding recurrently to part fund the implementation of IRIS across the county.

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Director of Public Health

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Constitutional Comments (SG 20/06/2013)

19. The Committee has responsibility for Public Health under its Terms of Reference and is the appropriate body to decide the issues set out in this report.

Financial Comments (ZKM 03/07/2013)

20. The financial implications of this report are outlined in paragraph 18.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

[1] Department of Health (2012) The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 www.dh.gsi.gov.uk/mandate

[1] Hall P and Smith K (2011) Analysis of the 2010/11 British Crime Survey Intimate Personal Violence split sample experiment. Home Office July 2011 accessed November 2012 http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/analysis-bcs-ipv-2011?view=Binary and http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Age+and+Sex

[1] Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime In England and Wales 2007/08) London: Home Office

[1] Feder,G et al (2011). Identification and Referral to Improve Safety of women experiencing Domestic Violence with a primary care training and support programme: a cluster randomised controlled trial. The Lancet October 13.

[1] Coid, J et al (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal Psychiatry* 2003: **183**; 332-39

Electoral Division(s) and Member(s) Affected All

[i] Department of Health (2012) The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 www.dh.gsi.gov.uk/mandate

[ii] Hall P and Smith K (2011) Analysis of the 2010/11 British Crime Survey Intimate Personal Violence split sample experiment. Home Office July 2011 accessed November 2012 http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/analysis-bcs-ipv-2011?view=Binary and http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Age+and+Sex

[iii] Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime In England and Wales 2007/08) London: Home Office

[iv] Feder,G et al (2011). Identification and Referral to Improve Safety of women experiencing Domestic Violence with a primary care training and support programme: a cluster randomised controlled trial. The Lancet October 13.

[v] Coid, J et al (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal Psychiatry* 2003: **183**; 332-39