STANDING together
against domestic violence

Health and Domestic Violence: Improving safety through screening

A report on what has been achieved at three health sites in West London

July 2003 - March 2004

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"With the intervention of the nurse at Charing Cross I was able to get help through ADVANCE. This was the first time I had ever talked to someone about the domestic violence and I am now able to see things differently."

– Survivor of domestic violence

"I had worked with ADVANCE before but when I went to the Walk in Centre, the nurse asked me if everything else was ok. I told her that things were getting bad at home and she told me to re-contact ADVANCE. I have now left home, taking my five children".

– Survivor of domestic violence

Foreword

This report is a review of the Standing Together Crime Reduction Programme Health Project, focusing on achievements and the complex issues encountered from July 2003 to March 2004. This project has proved to be challenging, interesting and rewarding for all those involved. We hope that this report will provide valuable learning information to others interested in embarking on similar work.

A number of appendices have been included which we hope will be useful to other projects and professionals interested in domestic violence screening based within health care. Copies of the screening protocols are available to be downloaded from our web site www.standingtogether.org.uk

A report on the achievements made during the initial period of funding (October 1999 to March 2002) is available in the report by Standing Together, entitled *Health and Domestic Violence: What Can Be Done?* A Crime Reduction Programme briefing paper on the health project which details the work carried out in the second phase of the project from April 2002 to March 2003 is also available from Standing Together.

Standing Together would like to thank the staff at Charing Cross Hospital A&E Department, Charing Cross Emergency Primary Care Access Service (EPCAS) and Parsons Green Walk In Centre, for their continued commitment to the project and implementing the screening protocols. In particular we would like to thank Accident and Emergency Consultant Hugh Millington, Sister Annie Joseph, Staff Nurse Zoe Hartwright (all from Charing Cross Hospital Accident and Emergency Department); Nurse Practitioner Sue Roberts and Lead Nurse Sue Stubberfield (both from the Walk In Centres). The administrative support staff at Parsons Green and Charing Cross Hospital also provided assistance to the Development Worker.

Standing Together is grateful to The Crown Prosecution Service for agreeing to the secondment of Victoria Hill as the Development Worker with Standing Together.

Victoria Hill
Development Worker
Standing Together Against Domestic Violence

An Introduction to The Health Project

Introduction to the report from Chair of the Health Steering Group - Mr Millington.

"The nurses and doctors working in Charing Cross Accident and Emergency Department have an understandable reluctance to identify and address problems such as domestic violence, for which there is no easy means of doing so, or solution. They are busy and will concentrate on a patient's presenting clinical problem (injury or illness) and deal with it, avoiding identifying a problem such as domestic violence. The existence of ADVANCE and the screening protocol developed by the Health Project has encouraged staff to identify domestic violence and offer help to women who disclose domestic violence.

We are able to offer a better and more complete service to our patients. This project has gone a long way to establishing it as routine practice.

As A&E Consultant and Chairman of the Health Steering Group, I am extremely grateful to Victoria Hill for all her hard work. Without her and her predecessors working as Development Workers with Standing Together, we would not be where we are.

The Health Project has been important and rewarding work for us all".

Background to Standing Together Against Domestic Violence

Standing Together co-ordinates the ground breaking multi-agency response to the crime of domestic violence in the London Borough of Hammersmith & Fulham. We have grown out of many years of multi-agency work by voluntary and statutory agencies in the borough. The project has been inspired by the work of the Domestic Abuse Intervention Project in Duluth USA. The co-ordinated response was launched in Fulham in November 1998 and extended to the whole Borough of Hammersmith and Fulham in December 2000. Standing Together commenced work with the Royal Borough of Kensington and Chelsea in October 2002, when the Specialist Domestic Violence Court at West London Magistrates Court opened.

The Standing Together Trust was set up in July 2001 to manage, carry forward and develop the pioneering work of the Standing Together partnership. The objectives of the Standing Together Charitable Trust are to promote for the public benefit the provision of services directed towards the prevention of domestic violence and to meet the needs of survivors of domestic violence and their families.

Standing Together aims to:

- Improve safety for survivors of domestic violence, from the moment of first contact with the criminal justice system through to the period after the abuser completes the sentence.
- Hold offenders accountable and responsible for their actions.
- Deliver more effective prosecution and sentencing of abusers.
- Ensure that the onus for doing so lies with the statutory and other agencies rather than the survivor.
- Whilst acknowledging that each agency maintains its independence, to ensure that all agencies involved work in an integrated and co-ordinated way to achieve these objectives.

- Provide accountability to the public, to survivors and to other agencies for the way in which domestic violence is handled.
- To test and develop effective policies, procedures and practical measures which can be integrated into the ongoing work of agencies.

The Operational Partners are:

- Metropolitan Police, Hammersmith & Fulham Division.
- ADVANCE, the Advocacy Project.
- The Crown Prosecution Service, West London Branch.
- The London Probation Area.
- The Hammersmith & Fulham Community Law Centre.
- The Domestic Violence Intervention Project (DVIP).
- Hammersmith Women's Aid (HWA).
- Awareness in Practice (specialist domestic violence training agency).
- London Borough of Hammersmith & Fulham Council (Community Safety Unit, Information Technology Services Department and Social Service Department).
- Charing Cross Hospital A&E Department (including Charing Cross EPCAS and Parsons Green Walk in Centre).
- West London Magistrates Court & Blackfriars Crown Court have observer status on the Steering Committee.

The operational work of Standing Together is managed by a Steering Committee made of up each participating agency, actively involved in the co-ordinated response.

Staff employed to carry out the work of co-ordination, information sharing and development are employed and managed by the Standing Together Trust. Member agencies are encouraged by the success of the partnership and they are agreed that this is the way in which they want to deal with domestic violence incidents in their Borough.

An Introduction to the Standing Together Health Project

The health project is based at three health sites within Hammersmith and Fulham:
Charing Cross Accident and Emergency Department (Charing Cross A&E), Charing Cross Emergency Primary Care Access Service (EPCAS) and Parsons Green Walk In Centre (WIC). Charing Cross Hospital forms part of the Hammersmith Hospitals Trust and is a large teaching hospital. EPCAS and the Parsons Green WIC are part of Hammersmith and Fulham Primary Care Trust and are Nurse Practitioner led services, providing treatment for minor injuries and illnesses. EPCAS operates out of Charing Cross A&E Department.

Standing Together's Health Project has been funded by the Home Office's Crime Reduction Programme for three years since October 1999 (originally funded for 18 months until March 2002), and was extended again to March 2004. The CRP grant in 2003/4 was at 50% of the previous years funding and this has provided; one advocate at ADVANCE (to take referrals from the health project); a half-time Development Worker to provide assistance to the medical facility and to

provide some hours of a training officer at Standing Together, to deliver training to medical staff on domestic violence and the screening protocols.

Aims and objectives of the health project

The aim of the health project was to create institutional change with regard to the health service's response to domestic violence.

The essential elements of the project in 2003/4 were:

- To implement protocols on domestic violence that include screening, documentation and referral.
- To train staff on domestic violence as an important health issue, screening and the health protocols.
- To implement necessary monitoring and evaluation procedures, so that an outside evaluator can measure the change in practice and its outcomes
- To increase the profile of domestic violence as an important health issue within the medical facility.

The final phase of the project (July 2003 – March 2004) focused on exploring further the opportunities of mainstreaming domestic violence interventions within both the Hospital Trust and the Hammersmith and Fulham Primary Care Trust.

1. To create and maintain an ethos at the selected health sites which acknowledges the existence and frequency of domestic violence; encourages patients and staff to name it and talk about it (in a way that avoids placing blame or responsibility with the victim) and actively counters these messages which victims commonly receive.

2a. To identify intimate partner violence through screening and through recognition of possible indicators of abuse. As an integral part of this process, to offer patients information materials, and support (via referrals to appropriate agencies).

2b. To track progress and outcomes for individuals who disclose domestic violence, in order to check how screening promotes safety and to enable appropriate feedback and recognition to be given to individual NHS practitioners.

3. Within the framework of the existing protocol, identify in the Health Steering Group the barriers to systematic screening and the solutions to overcome them, and incorporate these as appropriate in the protocol.

4. Where patients disclose current domestic violence, or where staff find out about it by other means, to offer a good quality co-ordinated response to domestic violence incidents presenting at the selected sites – in particular, via referral to the ADVANCE advocacy project.

5. To embed good practice in the selected health service settings, ensuring that all staff have received appropriate training in domestic violence as a health issue.

6. To identify and address any problems in getting prompt medical evidence from the A and E (Charing Cross) in order to benefit from the use of medical evidence in domestic violence cases at West London Magistrates Court.

7. To share information at regular intervals within the Steering Group (and with the Standing Together Committee and any other appropriate bodies) about all aspects of the project, in a way that does not identify individual patients, but does enable partners to discuss and manage the project.

8. To advance the mainstreaming of these initiatives in the Hammersmith and Fulham Primary Care Trust and the Hammersmith Hospitals Trust.

9. In all our work to prioritise the safety of survivors of domestic violence and their children, recognising that "no action" does nothing to increase safety and that inappropriate action may increase danger.

10. To produce a report on the project's work at the end of the year.

Limits of this project

- This project is a pilot and is therefore limited to three health sites in the London Borough of Hammersmith and Fulham.
- Questioning and recording practices had to be straightforward in order for this project to work. We were unable to identify whether those patients who had disclosed domestic violence once screened, had previously presented and disclosed domestic violence at other services. Standing Together would like to add this aspect to any future development of the pilot.
- We could only track those women who had accepted a referral to ADVANCE. Tracking referrals made to ADVANCE was essential as this provided valuable feedback to practitioners and this helped to demonstrate the impact of screening practices.
- We were unable to investigate and gather information on the wider impact of screening within the community. We can only presume that it is possible that other patients may learn that assistance can be obtained from the sites (through friends and family members) and attend those health sites themselves to access help.
- We do not know and were unable to establish whether women have been prevented from attending the health sites, because the perpetrator is aware that screening for domestic violence takes place at those locations or whether screening has placed any individuals in increased danger. We do not believe that the project has been running long enough to achieve such a reputation. We believe that the need for emergency health care would over ride such considerations and that it would take a major research project to establish this.

The Health Steering Group

At the start of the 2003/4 project, Mr Millington (A&E Consultant) proposed that a steering group for the project should be formed, whose task would be to advise and support the Standing Together Development Worker and thus ensure the project objectives could be met.

The Health Steering Group meets on a monthly basis, its role includes:

- Monitoring and evaluating how the project is operating in relation to its objectives.

- Identifying problems and solving them if possible, (or at least identify issues and blockages in enough detail to provide information for agencies to take decisions about changes to policy/practice).
- Devising and implementing ideas for change to systems and procedures based on operational knowledge, as appropriate.
- Providing a framework to guide the work of Standing Together's Development Worker.
- Reporting to Standing Together's Steering Committee and to any other appropriate bodies.

The membership of the Health Steering Group is drawn from a wide range of health care professionals, including managerial and operational staff from the health sites. This group was a key factor in moving the project forward.

Membership of the Health Steering Group:

- Hugh Millington - Consultant (Chair of HSG), Charing Cross Hospital A&E Dept.
- Annie Joseph - Sister, Charing Cross Hospital A&E Dept.
- Zoe Hartwright - Senior Staff Nurse, Charing Cross Hospital A&E Dept.
- Sue Roberts - DV lead nurse, EPCAS and Parsons Green Walk-in Centre.
- Sue Stubberfield - Lead Nurse (Attended from Dec 2003), Parsons Green Walk in Centre.
- Kristine Coan - Health Strategy Development Worker, London Borough Hammersmith and Fulham.
- Adrian Mayers (observer) - Head of Partnerships, Hammersmith and Fulham PCT.
- Sally Steadman - Advocate, ADVANCE.
- Beryl Foster - Director, Standing Together Against Domestic Violence.
- Victoria Hill - Development Worker, Standing Together Against Domestic Violence.

Role of the Development Worker

The Development Worker was seconded on a part time basis to the health project in mid July 2003. The first two months were focused on induction and making links with health staff. The Development Worker had responsibility for overseeing the progress of the project, monitoring the implementation of the protocols and providing support to the health sites. The worker also organised and facilitated the Health Steering Group meetings, progressed tasks, produced and distributed resource materials and collected monitoring information. The Development Worker also assumed responsibility for planning and delivering the protocol training.

Why Screen Patients for Domestic Violence?

Research has clearly shown the high volume of domestic violence presenting to health professionals. The effects of domestic abuse on a very wide range of health issues is accepted and there is a wide body of research from both the UK and USA that demonstrates the links between domestic violence and the negative impact it on health. In the USA, health departments provide the bulk of funding to domestic violence services. In 2001 Women's Aid highlighted the critical role the NHS has in responding to domestic violence.

The Department of Health has stated that the health and social costs and consequences of domestic violence are extensive and serious enough to constitute a major public health issue. The NHS has a particular contribution to make as almost all survivors of domestic violence come into contact with the health services at some point in their lives. Early identification and support can help reduce the cycle of repeat victimisation. The NHS is less likely to be seen as stigmatising than some other statutory services, and this creates a unique opportunity for health professionals to respond to people experiencing domestic violence – Department of Health Practitioners Domestic Violence Manual (2000).

The Royal College of Obstetrician and Gynaecologists Confidential Enquiry into Maternal Deaths in the United Kingdom report "Why Mothers Die 1997 – 1999" (2001) stated that although none of the 378 women featured in the report had been routinely questioned about domestic violence, 12% of the women whose death was reported to the enquiry had actually voluntarily disclosed domestic violence to a health care professional during their pregnancy. It also found that eight women in the enquiry were murdered by their partners or by close relatives. The RCOG has consistently recommended that routine domestic violence screening should take place during pregnancy.

An article published in the Emergency Medical Journal entitled "The experience of domestic violence by women attending an inner city accident and emergency department", (2004) concluded that that the prevalence of domestic violence in women attending an accident and emergency department is high and that most female patients are in favour of being asked about domestic violence.

It is widely accepted that the health service is one service that almost all survivors of domestic violence will come into contact with at some point in their lives, and many of these women have had little contact with other agencies responding to domestic violence. As few victims will openly disclose domestic violence, screening in a health care setting provides a safe place and opportunity for them to seek help, advice and support.

Benefits and Impact of Screening for Domestic Violence Within a Health Care Setting

For practitioners the provision of information, training and resources (on the health implications of domestic violence) helps to ensure that they know how to correctly respond to patients who are experiencing domestic violence. Training helps to improve staff confidence about how to "manage" disclosures of domestic violence, which has resulted in more patients being screened.

This project has demonstrated that the availability of a clear referral route via the ADVANCE Advocacy Project has enabled health staff to be confident about asking patients about domestic violence. The service provided by ADVANCE means that practitioners are able to deliver core business and be confident that specialist advice and support on domestic violence can be accessed.

There are also clear benefits to all patients who attend the health sites as conducting screening for domestic violence should help to improve the general standard of patient care being delivered.

Feedback from patients (both via referrals to ADVANCE, through consultations that Standing Together has held with survivors and also from practitioners) has consistently demonstrated that screening is widely welcomed and positively received by patients.

Screening for domestic violence sends a clear message that domestic violence is recognised as an important health issue, that it is unacceptable and that trained staff are available to provide advice if so needed. Screening ensures that individuals who disclose domestic violence can (if they accept it) receive appropriate and safe advice.

In addition, through the involvement with this project, both staff and patients are linked into the Standing Together Partnership and the co-ordinated response to domestic violence within the borough. This is an encouraging step towards improving victim/survivor safety and holding the perpetrator accountable.

The Screening Process and Protocols

The protocols were written to ensure that questioning was consistently and safely implemented. Safe practice was reinforced in the training, so that the practitioners understood the importance of asking the screening question in an appropriate manner and in a way that did not increase risk. The training also explained the importance of staff validating any disclosure of domestic violence and how to suggest support. The Health Steering Group agreed that in order to ensure best practice and safety of the patient and practitioner, members of staff would not be instructed to conduct screening, until they had received the screening protocol training.

In October 2003 the existing screening protocols were amended by Standing Together, in conjunction with the link nursing contacts at Charing Cross A&E and the Walk In Centres. This needed to be completed swiftly so that training on the protocols could be planned and delivered. Training needed to occur early on, so that a maximum number of staff could begin screening, to enable enough reliable data to be collected.

As Walk in Centre nurses rotate on a four-weekly basis between Parsons Green and Emergency Primary Care Access Service (EPCAS) it was agreed that two protocols should continue to be implemented. To limit unnecessary confusion it was agreed that Parsons Green should have a separate protocol and that EPCAS should be combined with Charing Cross A&E. This decision was based mainly on the way in which patient care is delivered and the presence of doctors at Charing Cross.

The original protocols had been developed following detailed consultation with nurses. Amendments were made to the protocols, taking into account the issues raised by staff and the various problems with the project which Standing Together had identified. It was agreed by the Health Steering Group that Parsons Green Walk In Centre and Charing Cross EPCAS would screen all female patients over the age of 16 years, and male patients with indicators of abuse as part of routine practice. It was accepted that routine screening at A&E might not always be achievable, primarily due to the nature of the acute service and number of staff that may see the patient. The implementation of routine screening at A&E was considered to be a long-term objective. For patient safety and confidentiality, it was also deemed most appropriate for screening to be conducted at Triage – where the patient is first seen and assessed.

How to Ask the Screening Question

Within the protocol, examples of screening questions were included for the practitioners to utilise. Although a prescriptive approach was not considered necessary, practitioners were encouraged to select an example outlined in the protocol and to use them until they are confident to adapt the questions to their own style.

Practitioners commence screening by asking the patient a framing question, so to explain to the patient the reason behind the enquiry e.g. *"As domestic violence is so common we now ask all our female patients about it"*. They then follow this with a direct question (where appropriate adapting it to the injury that the patient had presented with) e.g. *"Did your partner cause this injury to you/are you in a relationship with someone who hurts or threatens you?"* Practitioners were instructed not to ask questions or to use phrases such as *"why did this happen?"* as this could be interpreted by the survivor as being "victim blaming."

Some practitioners did express frustration that despite screening many patients for domestic violence few disclosures are made to them, and fewer numbers of patients will agree to a referral to ADVANCE. Due to the complex dynamics of domestic violence this is not a surprising discovery, but it demonstrates that staff are keen to help their patients. It was important for staff to understand that whilst patients would not always make disclosures, it remains necessary for them to screen patients in accordance with the protocol as disclosing domestic violence and accepting support are long and difficult processes. Once the practice of screening for domestic violence becomes more routine and established, more patients may attend the health sites expecting to be asked about domestic violence and be willing and ready to receive help. Routine screening is also necessary so to ensure that screening practices are not based upon generalisations and stereotypes.

Protocol Resources

A wide range of resources were used to support the implementation of the protocols. Following staff feedback (both from training sessions as well as informal consultations), the need for clear, accessible and concise information was identified. In the public reception/waiting areas at Charing Cross and at Parsons Green (A&E and EPCAS share the same waiting area) a range of Women's Aid advice and information leaflets were available. In addition Women's Aid advice line posters were displayed in key locations and advice line stickers were also placed in the female toilets. DVIP Women's Service leaflets and the DVIP AL – Aman Family Safety Project in both Arabic and English (Arab Women's Support Service) were also displayed.

Standing Together did previously devise an A3 sized health and domestic violence poster, however this was not used on an ongoing basis during the health project due to its size, (it was considered too large to be displayed in the waiting areas).

The provision of resources helped practitioners to "set the scene" with patients and helped to explain that domestic violence would be taken seriously. ADVANCE leaflets were available in all of the clinical rooms at Parsons Green and in the Triage rooms at Charing Cross, as well as in the majors and minors areas.

Standing Together also devised a small credit sized card which had a range of local and national help line numbers on it (including domestic violence help line numbers). This resource was useful for when a practitioner had conducted screening and was either suspicious of domestic violence or was unable to provide the patient with a domestic violence leaflet for safety reasons. These cards were

displayed in holders positioned on the computers, which had a prompt on it for staff to screen for domestic violence before they offered the card (appendix number one - page number 28).

A pocket sized laminated protocol "prompt" card (appendix number two - page number 29) was designed for staff and given to participants at the screening protocol training sessions. This prompt card outlines the five key stages of the protocol which staff could retain and refer to when needed.

On a monthly basis all of these resources were checked, counted and replenished by the Health Development Worker. Staff widely welcomed the range of resources displayed, stating that they were informative and helpful.

Following feedback from practitioners it was clear that they also wanted accessible resources, which they could easily refer to when they needed information on domestic violence. Standing Together considered this and devised Domestic Violence Resource Information Files. These folders contained leaflets, the protocol and all of the related resources, as well as good practice guidance information for staff to refer to. They were also placed in the clinical and triage rooms, as well as in the central areas – Majors and Minors at Charing Cross, alongside the screening recording books. The domestic violence resources are yellow (folders, screening books and patient card stickers) in order to provide clear visible links for staff. This is a colour not used in any other coding system within the health sites.

Monitoring and Recording Screening Practices

In this phase of the project it was essential that the difficulties in obtaining monitoring information on screening practices were swiftly identified and resolved. Clarification of the recording process was urgently required and this involved extensive liaison with the link staff at the health sites so that monitoring could occur.

Due to the previous difficulties experienced with recording screening practices this was an urgent matter that needed to be resolved, in order for screening data to be collected to help evaluate the project. Unfortunately it had not been possible to obtain data on the total numbers of patients being seen at each site. Standing Together was unable to compare screening rates against patient numbers so that the frequency of screening could be "robustly" monitored.

The recording mechanisms also needed to be revised and then incorporated into the protocols. Following detailed discussions with the nurses it was agreed that a paper based recording system needed to be devised, so that staff could easily record when they had conducted the screening and the subsequent outcome. In order to identify what the barriers to conducting domestic screening were, it was also agreed that staff would be required to record the reasons why they had not been able to conduct screening.

This strategy of recording was particularly useful to the project as it provided essential information on the reasons why staff were not routinely screening patients. This information gave an insight in to the working culture in the health sites, operational constraints as well as highlighting professional concerns. This method of recording also served to reinforce the principle behind the need to record and for staff to make safety assessments before asking patients about domestic violence. It was also explained to staff that these issues would be fed back to the Health Steering Group, with a view to resolving any problems raised.

Electronic monitoring systems

In July 2003 the Health Steering Group was advised that the computer system for the Parsons Green Walk In Centre could be amended so that domestic violence screening could be added to it. This was particularly encouraging as it was originally hoped that it would serve to remind staff to screen and would be a significant step towards mainstreaming practice. It was also hoped that it would eventually provide accurate monitoring information.

Following liaison with the IT Consultant working on the National Walk In Centre Policy Team at the Dept of Health, it was established that Special Patients Notes Functionality (SPNF) could not provide the project with the detailed monitoring information required. This is because the SPNF only enables the nurses to apply a "free text" note and there is no drop down menu for the nurse to select a suitable option. The free text box provides only a very basic report consisting of the patient's date of birth and their name. To obtain other monitoring information such as whether the question was asked, the disclosure and resulting action, each case file note would have to be accessed to obtain this information. This would undermine patient confidentiality and would therefore mean Standing Together could not access the information.

The use of Special Patient Note Functionality could have been used to support a paper based recording system but the free text would not be able to contain a template like the paper system. This would mean nurses would have to complete both systems that would take more time. This was considered as being an extra task that it could be seen as unnecessary and become an additional barrier for staff to conduct and record screening. As the SPNF was considered unsuitable to meet the needs of the project it was necessary to continue the implementation of a paper based recording system.

The capabilities of the future A&E computer system to include electronic recording of domestic violence screening practice would be worthwhile considering as the screening process evolves, even after this pilot. Time constraints prevented any possible exploration of this with the systems designers.

The implemented recording system – paper based

The same paper based screening recording system was agreed for all of the health sites. This comprised of a yellow folder containing the screening information recording boxes (overleaf). A box is to be completed every time a female patient over the age of 16 years is seen (regardless of their medical condition) as well as male patients with indicators of domestic violence, even when the screening question has not been asked. Although it was accepted that routine screening may be more difficult to implement within acute services, it was repeatedly emphasised to practitioners, in order to prevent screening practices being based on assumptions about domestic violence.

The screening information box contains the core information required to help evaluate the project, and has been streamlined so the recording process is quick and easy for the practitioner to conduct. It contains no information that would identify a patient, which would comprise confidentiality and their safety. It was necessary to refine the recording process so practitioners would be more inclined to engage with the screening and recording process. It was agreed that the screening information box should be completed after the triage/assessment nurse has seen each patient and that they are required to tick off the corresponding reason to explain why screening was not conducted.

Screening Information Recording Box

Date ……	Screening question asked? ❑ Yes ❑ No
Gender	If no, tick reason why:
❑ Male ❑ Female	❑ language problem ❑ no room available ❑ with partner ❑ with child ❑ not trained in IPV screening ❑ other …….
Ethnicity/Ethnic origin	Was domestic violence disclosed? ❑ Yes ❑ No
……..	IPV assessment proforma completed? ❑ Yes ❑ No
Age ❑ 16–25 ❑ 26–40	Domestic violence suspected? ❑ Yes ❑ No ❑ Unsure
❑ 41–64 ❑ 65+	Domestic violence information leaflet/card provided?
	❑ Yes ❑ No
	Referral made to ADVANCE? ❑ Yes ❑ No ❑ Suggested

At Charing Cross once screening has been conducted, the nurse is required to place a yellow dot sticker on the patient's card. This is a quick and confidential indicator to other colleagues who may see the patient that screening has been conducted. This is aimed at preventing duplicate screening, which may be deemed intrusive by the patient. In cases when a disclosure of domestic violence is made other processes as outlined in the protocol are then followed, such as the assignment of a contact nurse and a safety assessment. This serves to notify colleagues that it is a domestic violence case.

In cases were domestic violence is disclosed by a patient, staff are required to outline the benefits of completing an Intimate Partner Violence (IPV) Assessment Proforma, Appendix 5, page 32. This proforma must be completed with the patient's consent, is stored confidentially separate from their medical notes and can be used in the future as medical evidence or for when seeking to obtain emergency housing, an injunction or other civil order. The proforma contains information for the ADVANCE referral as well as a body map and chart for the doctor to complete when examining domestic violence related injuries. So that doctors can photograph domestic violence related injuries, a Polaroid camera with film has been supplied to Charing Cross.

Liaison and Communication with the Health Sites

The Health Development Worker attended all of the sites on a regular basis (often as part of delivering the protocol training), which has meant that productive working relationships with managers and staff developed. This resulted in improved communications, co-operation and continuous progress being made. Staff have been inclined to approach and ask questions or respond to requests for informal feedback. There has been regular contact with the lead nurses at the walk in centres and at A&E, and the Walk In Centre Link Nurse has also been attending the Standing Together Steering Committee meetings as the health project representative.

The introduction of email at Charing Cross A&E has meant that the link nurse contacts can be more easily sent information. The attendance of the Lead Walk In Centre Nurse at the Health Steering Group has also meant that there is an additional managerial link representing the Walk In Centres. This has significantly improved the Walk In Centres screening rates. Standing Together are pleased that they have secured agreement from the Clinical Nurse Manager at Charing Cross to attend future Health steering Group meetings from April 2004. The value of regular face to face contact with practitioners must not be under estimated in helping to progress issues.

On some rare occasions meetings with staff at Charing Cross A&E have been cancelled or have been briefer than expected, due to the volume of work in the department. However, the key link staff have all remained enthusiastic about this work. Their level of commitment is reflected in the progress made to date.

Key Project Monitoring Results

Training delivered from August 2003 – March 2004

Training Performance Measures	Number of Staff Trained
Total number of staff trained on Domestic Violence awareness.	**39** *Includes A&E Senior House Officers, Registrars, Consultants and Walk in Centre Nurses only.*
Total number of staff trained on Domestic Violence Screening Protocol.	**56** *Includes A&E Senior House Officers, Registrars, Consultants, Walk in Centre and A&E Nurses.*

Screening rates from December 2003 – March 2004

Screening Performance Measures	Screening Rates
Total number of patients screened for Domestic Violence.	**442**
Total number of screened patients who did disclose Domestic Violence.	**43**

Data source: Screening Recording Books are located in the Clinical Rooms at Parsons Green, within EPCAS and also in the Triage Rooms at Charing Cross A&E.

- 9% of screening questions result in a disclosure of domestic violence.
- 55% of all disclosures of domestic violence have resulted in a referral being made to ADVANCE.
- Anecdotal evidence suggests that that the screening rate may be higher than the monitoring data indicates, due to the low recorded screening rate within the Charing Cross A&E Department and the high rate of referrals being made to ADVANCE.

Referrals and Information monitoring figures from July 2003 – March 2004

Other Performance Measures	Figures
Total number of referrals made to ADVANCE from the health sites.	**21*** *(19 direct & 2 self referrals)*
Total number of Domestic Violence leaflets taken.	**700#**

** This figure is the number of referrals made to ADVANCE by health. A direct referral is when the practitioner makes a referral on behalf of the patient. A self-referral is when the patient takes away information and later contacts ADVANCE. This figure is obtained directly from ADVANCE at the end of month.*

 # This figure includes Women's Aid and DVIP Women's Service leaflets taken from the public waiting areas, Triage and Clinical rooms. We are unable to track who takes the leaflets and what happens as a result e.g. contact to Women's Aid national advice line.

Training the Staff

As two slightly different protocols were developed, it was appropriate that the training should be delivered separately to the Charing Cross A&E Nurses and to the Walk In Centre Nurses. As the protocols were slightly different, the training for the walk in centre nurses was amended as these nurses had two protocols to learn and follow. In addition, due to the different role and function of doctors, A&E Nurses and Walk In Centre nurses, it was also agreed that each group of practitioners should be trained in separate groups. This decision was also taken due to the time constraints and it being impossible to train the different staff groups together. Our approach ensured that the training would be relevant to the particular health site and how patient care is delivered, as well as focusing on the practitioner's specific role and related concerns.

Between August 2003 and March 2004 Standing Together delivered in total seventeen training sessions to health staff. This has comprised both screening and domestic violence awareness raising training sessions, delivered to A&E and Walk in Centre nurses as well as Senior House Officers (ten new SHO's enter the department every six months), Registrars and Consultants. Standing Together's Training and Information Officer designed a general domestic violence awareness session, which focused on the impact domestic violence has on health and a brief insight into the dynamics of domestic violence. The Training Officer provided assistance and expertise to the Development Worker in designing and delivering the protocol training session.

Training Session Title: Domestic Violence: An Important Health Issue.

- Four awareness-raising sessions were delivered.
- Thirteen Walk In Centre Nurses have been trained out of 21 staff (total staff includes two lead nurses, two GPs and two Emergency Nurse Practitioners). GPs and ENP were not trained.
- Twenty three Senior House Officers from A&E have been trained.

Peta Sissons, (Standing Together's Training and Information Officer) supported by the Health Project Development Worker, delivered the domestic violence awareness training. These sessions were delivered during structured learning time for both A&E Doctors and Walk In Centre Nurses. The sessions lasted for approximately one and a half hours. The training allowed participants to discuss the issues in a safe environment, where professional dilemmas around the subject could be shared and resolved. A wide range of materials were utilised, including a short video clip to enable participants to understand the complexity and range of behaviours involved in domestic violence. Feedback from staff on this training has been hugely positive, and has demonstrated that many practitioners have a keen interest in the subject and are eager to learn more about it. Objectives for this training can be located in appendix number three – page number 30.

Training Session Title: Intimate Partner Violence Protocol – Screening, Documenting and Making Referrals.

- Ten sessions at Charing Cross A&E for nurses.
- A total of twenty nine (out of 35) A&E Nurses have now received this training.
- There has been three sessions delivered to the Walk In Centre Nurses (Parsons Green and EPCAS).
- A total of seventeen (out of 21) Walk In Centre staff have received this training.
- Nine A&E doctors/SHOs have been trained on the protocol.

As there has been no dedicated Training Sister in post at Charing Cross A&E, arranging training was logistically difficult due to the shift work pattern and operational constraints. Most of the A&E Nurses protocol training sessions were delivered early in the morning when the department was less busy, so that staff could be released to attend. Although this approach was both resource and time intensive, it made the training more accessible and a large number of staff were subsequently trained. Twenty nine out of thirty five permanent nurses were trained in this period.

Senior staff were trained last as they were required to cover the department to enable the release of more "junior" staff for the training. As it took longer than expected to train the senior staff members, the screening rates within A&E have not reached their potential level. This is because the senior/experienced nurses fulfil the general assessment role within Triage, where the main bulk of screening is to be conducted.

The protocol training session was an hour in duration. With the small number of participants in each group, this meant that the protocol(s) could be explained and that the sessions were not interrupted, when the department became busy. The protocol was explained as a process with five clear steps, which the participants could easily memorise.

Due to resource limitations, agency nurses were not trained and were therefore unable to conduct screening. This may have affected screening and referral rates, although two regular "bank" nurses from the Walk In Centres were trained on the protocols.

It was also not possible for Standing Together to deliver both the awareness raising and the protocol training to every member of staff due to time and resource constraints. For A&E Nurses in particular it was operationally difficult to organise and deliver training sessions to large numbers of staff. A realistic and pragmatic approach (i.e. one to one sessions) had to be agreed and followed to ensure that routine screening would be conducted as soon as possible. Despite these difficulties, twenty four staff members from the three health sites did receive both sessions of the domestic violence training.

In addition, some aspects of awareness raising information was incorporated into the protocol training, especially for practitioners who were not able to attend the domestic violence awareness training. This information was also reinforced by course materials that were given to the participants.

Standing Together produced certificates for staff who attended the sessions for their training and development portfolios. Objectives for this training can be located in appendix number four – page number 31.

Training feedback and points raised by participants

Participants were asked at the end of training session to complete an evaluation/feedback form. There were common themes in the feedback. Most of the staff stated that they found the training useful because it provided them with a better understanding of domestic violence. A number of participants said they were now more likely to ask patients about domestic violence.

The shortage of training time was a major concern of participants, who frequently stated in their feedback that they wanted to practice asking the screening questions in the training session (possibly in the form of role-play). This would require longer sessions so that this could be explored in more detail. The lack of training time was initially thought to have served as a barrier to screening as staff wanted to be able to practice asking screening questions with their colleagues in a safe learning environment, to gain confidence before conducting screening with patients. Whilst this is entirely understandable, it is evident that a large number of staff have "gone live" and started screening without this extra training input.

Many participants said that they would have preferred being trained in a larger group, so that they could practice asking the screening questions with each other and discuss practice issues with their colleagues. Some staff members said that the receptionists should also be trained on domestic violence issues so that they are aware of safety issues and the screening protocol.

Overall, the staff were keen and interested in the protocols and have understood the benefits they provided. Some did not feel confident about screening due to the lack of real practical experience. Some participants asked for mentoring, on site support and more accessible information to help resolve these anxieties.

Action taken by Standing Together on the feedback

- Following the request for more accessible information Domestic Violence Information Resource Folders were created and distributed to each triage and clinical room, as well in the majors and minors at Charing Cross, so that staff can easily access information.
- A monthly progress table that details the project's "headlines" are both displayed in the staff rooms. Staff are also advised of monthly head line figures either through staff meetings for the Walk In Centre nurses or via email for A&E staff.
- Regular visits by the Health Development Worker continue to the health sites.

Comments made by participants following the training

"Have tended not to want to get too involved in the past. Your presentation has given me the push needed to get involved and offer help."

"Like many doctors I have not wanted to ask about domestic violence, because I didn't think I could do anything. Now I realise I can do something to help, and now I will do."

The Barriers to Implementing IPV Screening in a Health Care Setting.

The Development Worker has actively sought feedback from health practitioners on the screening process and protocol in order to establish and resolve the barriers are to protocol implementation. This was an important process so that the protocols could be amended, in order to achieve the

objective of routine screening. A number of key themes emerged through the feedback (both qualitative and quantitative), that was obtained on an informal basis. The Health Development Worker approached staff to seek their views when attending the health sites and also examined the collated entries in the screening recording books.

When considering this feedback it is important to understand that domestic violence interventions are not currently key performance/delivery targets within the NHS. Screening for domestic violence is an activity that has to be conducted above and beyond normal duties. Staff have recognised that domestic violence is common amongst patients and it is therefore important to build upon this interest, if screening is to be successful and eventually become routine practice. Standing Together has been fortunate in also having a wealth of feedback from the training to analyse, to assist this process and to understand working cultures and constraints.

Workload

Staff have stated that the Triage queue is frequently too long which has meant that staff in A&E have been unable able to regularly screen patients. This problem is added to when there are only a few senior staff on each shift, as these senior staff members are needed to triage patients. There are key priority targets for seeing and treating patients and these may have impacted on the screening figures, as staff feel they need to process patients and do not have time to ask the screening question and/or deal with any subsequent disclosure.

Domestic violence is not an NHS target

As domestic violence is not currently a nationally set target, screening is often viewed as an "additional" thing for busy staff to remember. As screening is a new procedure, staff have stated that they need a constant reminder to screen patients for domestic violence, until it becomes embedded into their practice. Routine screening is a long-term cultural change to working practices, which will require leadership and support, if it is to be maintained, when this project eventually concludes. To help prompt staff, Standing Together has placed leaflets and posters about screening patients in each of the clinical and triage rooms.

Staff confidence

Standing Together has found that some staff have felt anxious about screening in case a patient does actually disclose domestic violence. Some practitioners have stated that they feel that they do not have the time or the level of confidence to deal with disclosures. Staff stated that they need experience to build upon the training to increase their confidence so they feel competent in screening patients. In addition as domestic violence is a complex, sensitive issue which is such a prevalent problem for society we must remember that some members of staff may indeed by survivors of abuse, which may influence their willingness to screen patients.

Following discussions with new members of staff some expressed caution in screening patients as they felt that were still gaining confidence in their basic nursing practice. New members of staff have stated that they consider the screening protocol as an "extra" thing to remember to do and get right. Some of the new staff stated that once they feel more confident about their practice in general then they would be more confident to conduct screening.

At first, staff did frequently express concern about asking patients about domestic violence due to its private and sensitive nature. Using feedback from survivors, Standing Together was able to

demonstrate to staff that questioning about domestic violence was welcomed by women, when asked in an appropriate way.

The consultation exercise that Standing Together conducted with women who have experienced domestic violence and have used the health services in February and October 2002 provided valuable information that was used to address the practitioners concerns about screening for domestic violence. One woman's comments on health based screening said ***"I think it is quite important, because in a way, the other person initiates the conversation about that. For the women it is very hard being the first time to tell someone, listen this is my problem."*** (Two separate reports – "Survivors Speak" and "Heard Not Judged" – which cover the findings and methodology of the consultations are available from Standing Together).

Subsequent feedback from staff who had screened patients has also been helpful in allaying their colleagues concerns, as the overwhelming response from patients who have been asked about domestic violence is welcoming and positive.

Liaison and communication

Within A&E, nurses have stated that the absence of regular team meetings means it is difficult to discuss practice issues with colleagues. Staff stated that communication across the shifts and between staff is often limited, due to time constraints and workload demands. This may have affected the speed at which the protocol within the department was implemented.

How patient care is delivered

Even in the cases when an individual presents with a minor injury at Charing Cross, they may often be dealt with by a wide variety of people. Although the protocol sets out that the Triage Nurse should ideally conduct screening, if this has not been possible, its is currently unlikely that screening will be conducted elsewhere in the department. With more of the SHO's, Registrars and Consultants within A&E receiving training this problem may be resolved. As more staff are aware of the issues they may be more inclined and more confident to enquire about domestic violence, if they see that screening has not been done.

Other common barriers identified have included language/interpreter difficulties and staff not having a suitable room available to screen patients in.

ADVANCE Advocacy Project

From feedback previously gathered we were aware that the participation of the health service in the project would have been limited without the support provided by ADVANCE. Medical staff are not able to provide the level of detailed advice and support required. The availability of advocates 7 days a week and 24 hours a day has been positively received by those staff, especially those working within A&E. The referrals that ADVANCE receives from the health project are usually "acute cases" where swift intervention is needed.

Referral rate and process

The monthly referral numbers to ADVANCE have fluctuated between July 2003 and March 2004. An analysis of the referrals made in this period show that a core group of practitioners continue to make referrals to ADVANCE. We have seen a growing number of practitioners now making regular

referrals, for example following the Senior House Officer training there has been an increase in the number of SHOs and Registrars making referrals.

In order to increase the number of referrals made to ADVANCE, health staff were trained on the work of ADVANCE. They were encouraged to explain the range of support available from ADVANCE to the patient, rather than just supplying a leaflet and suggesting that they make contact. The referral rates continue to improve with 19 direct referrals and two self-referrals being made between July 2003 and March 2004. The increase in the monthly referral figures highlights the benefit of the training. It shows that more staff are now engaging in the screening process and are asking patients about domestic violence in a way that encourages a disclosure and a referral.

In several of these referrals an Advocate from ADVANCE was able to attend Charing Cross to provide support to the survivor, outlining options, giving advice and support. Furthermore ADVANCE also give support and advice to the staff. This is usually around how to deal with the case in a safe and sensitive way. For example, ADVANCE gave advice to a practitioner about not approaching the perpetrator and supporting their decision to call the police.

ADVANCE also give confidential advice to practitioners regarding anonymous clients. For example there was a case where a practitioner made extensive arrangements to refer a patient to ADVANCE but in the end she declined the referral. ADVANCE was able to help the practitioner understand that women may make many attempts to seek help and leave before being successful. ADVANCE also attends the Health Steering Group. This enables them to feedback statistics and aspects of good and bad practice. ADVANCE has also contributed to training the staff, outlining the referral process and the services they offer.

ADVANCE has also encouraged women referred to them by the police, to seek medical help for their injuries. The documenting of injuries creates a record of the abuse for when she does want to take action through the criminal justice system.

ADVANCE clients' comments on the health project

Part of ADVANCE's ethos is to keep the survivors voice at the centre of any response. Women who are referred to ADVANCE have been very supportive of this project. Importantly – they would like to see all health professionals using this opportunity. One of ADVANCE's clients stated:

"With the intervention through the nurse at Charing Cross I was able to get help through ADVANCE. This was the first time I had ever talked to someone about the domestic violence and I am now able to see things differently".

Screening all women over the age of sixteen for domestic violence has provided one woman the support to re-engage with ADVANCE. She presented with an ailment unrelated to the domestic violence and was screened (as set out in the protocol).

"I had worked with ADVANCE before but when I went to the Walk In the nurse asked if everything else was ok. I told her that things were getting bad at home and she told me to re-contact ADVANCE. I have now left the home taking my five children with me."

Women have also told ADVANCE that the screening process takes the burden from them about telling people about what's happening to them, because it becomes easier to explain when asked directly. It is therefore crucial that the practitioner's response validates their disclosure and ensures their safety.

One client who was taken to hospital after a severe assault told ADVANCE:

"The nurses were really nice, I was in such a state and appreciated the paramedics telling the nurses that I had suffered a domestic violence incident. The body maps helped me point our all of the places I had been injured."

Other good practice

One client said that the hospital staff were very aware about her safety.

"They wouldn't allow anyone to come and see me who I hadn't named. They were really aware that my partner could've attended at any point."

Another example of practitioners thinking about survivor's safety occurred when a perpetrator brought his partner to the hospital for treatment for a domestic violence injury. The woman was admitted, was screened and disclosed domestic violence. The woman did not know what to do and with her consent the practitioner informed the perpetrator she would be kept in overnight for observation. This gave the woman time to think about her options and her safety.

On one occasion a "double" referral to ADVANCE was made by both A&E and the police who originally attended the address. This is an excellent example of good practice, and highlights that both agencies worked well to encourage contact with ADVANCE. This approach serves to reinforce to the woman that there is help and support available to her in the community and that domestic violence is taken seriously.

The above examples clearly demonstrate just how effective the intervention can be. We believe that some of the women who have received help through the screening process are actually safer now.

Self-referrals

Information from ADVANCE has indicated that two women who were screened (one at Charing Cross and one from Parsons Green), who at first declined a direct referral but took away information did contact ADVANCE independently later on. The two self-referrals have been used to demonstrate to staff that although they may only occasionally have patients disclosing domestic violence to them and accepting a referral, there is an "unseen" benefit to their screening practices.

"When this project began we didn't know what the outcomes could be, now we can see there are many positives from early intervention. This has varied from staff feeling more confident when asking the questions and providing immediate assistance to women, to receiving referrals for women who would not have previously come to our attention. Women are now getting the support they need to increase their safety becoming more aware of their options and knowing that there is help available. This partnership has helped us work together to make women and children safer within Hammersmith & Fulham." Sally Steadman ADVANCE Advocate.

The Health Project Seminar

Standing Together organised a Health Project Seminar which was chaired by Mr Millington (A&E Consultant) and was hosted at Charing Cross Hospital in March 2004. The seminar was attended by a wide range of local health professionals and it provided an opportunity for Standing Together to outline the work that had been conducted since July 2003, what had been achieved and to share the monitoring data gathered.

Sue Roberts and Annie Joseph who are lead practitioners from the health sites for the project both gave presentations on their perspectives and roles in the project. This provided a valuable insight into their experiences of the project as they spoke of the benefits of screening patients, peer learning and support and how their involvement in the project has been a valuable and rewarding experience for them.

Sally Steadman an Advocate from ADVANCE also gave a presentation that focused on the survivor's positive responses to the project. The feedback from the women who had been referred to them via the health project enabled the survivor's stories to be heard and also served to reinforce the message that health based screening for domestic violence has helped to make women safer.

Other speakers at the seminar were Anthony Wills (Trustee of Standing Together and partnership advisor at Hammersmith and Fulham Town Hall) who outlined the importance of having health involved in partnership interventions. Peta Sissons (Standing Together Training and Information Officer) spoke about why it is important to screen for domestic violence within health settings and Beryl Foster OBE (Standing Together Director) outlined the future plans for the project.

Sally Hargreaves (Chief Executive of Hammersmith and Fulham PCT) also attended the seminar and gave the closing comments. She supported the project stating that domestic violence should be "core training" for all staff. She added that it could possibly be included with other subjects such as child protection, which also provides many professional dilemmas. GP's were specifically referred to as professionals well placed to screen and refer patients to specialist services.

Questions from the audience included whether the project would be extended further to new health sites and services and clarification of the current funding position. The interest raised by this seminar has formed the basis for planning new health pilot project with Maternity Services at Queen Charlottes Hospital.

Achievements of the Health Project

This phase of the project has witnessed encouraging progress towards the implementation of the protocols. Although routine screening has not yet been established across the health sites, it is clear that improvements continue to be made. It is important that the progress made to date is viewed against the backdrop of operational constraints, staff turn over and the development of staff confidence to engage in domestic violence screening. The project has certainly made sound progress towards achieving the aims and objectives that were agreed for this period.

A significant achievement so far has been the large number of staff who have been trained on the screening protocol, despite the absence of set training days. This has been the result of imaginative problem solving, liaison and co-operation with the management and staff at the health sites and its impact should not be under estimated. Feedback from the training has been positive and has shown that staff are generally keen to discuss the issues and get involved with the screening protocol.

It is clear that the issue of domestic violence is becoming more visible within the health sites, and that it is something that requires practitioners to be aware of and act upon.

The monitoring data indicates that the frequency of screening has significantly increased.

The dialogue with the Hammersmith and Fulham PCT about the possibility of future training is a welcome advancement towards the mainstreaming aim of the project. Although more work will be necessary on this, it indicates that the training on the protocol has been well received and positive

feedback has spread through the PCT. At the health project seminar a commitment was given to domestic violence training from the PCT.

Practice observed from the Specialist Domestic Violence Court at West London Magistrates Court, (which Standing Together co-ordinates), indicates that the quality and timeliness of medical evidence from Charing Cross A&E has improved. The introduction and training on the Intimate Partner Violence Assessment Proforma may have assisted with this. More work needs to be done to improve practices with the other sources of medical evidence, which are outside the remit of this project.

The Health Steering Group has proved to be a productive environment in which to share information and successfully manage the project. It has enabled problems to be resolved swiftly and was an excellent arena in which to discuss and take forward issues rising from staff feedback. The involvement of practitioners and managers (both senior and middle) in this group has helped ensure its effectiveness.

Referrals to the ADVANCE Advocacy Project have significantly increased.

The health project has encouraged local debate within the health service (both within the PCT and Hammersmith Hospital Trust) on domestic violence service provisions and what other services can be developed. The project has also contributed to the increase of interest in the area of health and links to domestic violence especially within the Hammersmith and Fulham Domestic Violence Forum.

The Commission for Health Improvement (CHI) will be visiting Hammersmith and Fulham PCT in May 2004. The Health Project has been put forward by the PCT as a good practice example of partnership working.

Lessons Learnt

The work undertaken to implement the protocols has highlighted a willingness of staff to address the issue of domestic violence in their practice. Whilst there has been progress on the rate at which patients are being screened for domestic violence, various challenges to the implementation of the protocols has meant that the moves towards routine screening and documentation have been slower than first expected.

Whilst this has been frustrating at times, it is acknowledged that development work by its very nature is long term, and progress is often incremental. It does take time for good practice to be established and consolidated. Regular feedback and positive reinforcement is needed so that experience can be shared and for staff confidence to increase. Long-term changes take time to be achieved within any organisational setting, as working cultures and practices are complex to understand and work within. Challenging working practices has also been difficult, as domestic violence is not currently a NHS target. Progress on the project must be viewed in this context, as any significant changes will not be possible without domestic violence interventions becoming institutionalised throughout the National Health Service.

We hope that the lessons we have learnt through this project will be helpful to others looking at developing health based domestic violence interventions. The points outlined below are diverse and demonstrate the complexities involved when attempting to embed the protocols into practice.

- A flexible approach is needed to deliver training to operational staff.
- Resources for staff need to be clear, concise and accessible.

- Staff must be regularly kept informed of progress and developments, in order to keep them engaged and retain their interest.
- It is important and necessary to offer encouragement to staff, to listen to their concerns and act upon them swiftly.
- Face to face contact ensures regular liaison and the development of effective working relationships.
- The protocols are not set in stone and can be amended when they need to be.
- Support from a range of key staff (for example senior and middle managers as well as front line practitioners), is needed in order to ensure that the work is embedded. If staff feel supported in this type of work we have seen that they are more likely to engage with the project and work according to the protocol.
- Implementing changes in working practices takes time to be embraced and embedded.
- Parsons Green residents who attend the Walk In Centre, disclose domestic violence and need doctor/hospital treatment for a domestic violence injury are likely to attend Chelsea and Westminster Hospital, who are not involved in this project.
- Although there has been a rise in the referral rate, a core group of practitioners continue to be the main sources of referral to ADVANCE. More work is needed to spread this practice and to embed the ethos of routine screening of patients.

The Project Exit Plan

Partnership working is the key to the success of Standing Together. Standing Together is hopeful that when this project finishes in its current form (scheduled exit date is September 2004), the working relationships that have been developed over the past three years will continue.

An exit plan has been devised in order to help maintain the practice of domestic violence screening within the existing health sites. This will be necessary so that domestic violence remains an issue for practitioners to be aware of and respond to. The exit plan has been devised with the understanding that the Hammersmith and Fulham Primary Care Trust is still settling into its new role and its funding is fully committed on their core health services. The provision of domestic violence services within the health service is currently limited to this project. The exit plan is now scheduled to be implemented at the end of September 2004 when funding is due to finish, when it is likely that the project will be managed internally by each of the sites.

What Standing Together will provide as part of the exit plan

Before the end of the project (currently scheduled for the end of September 2004) Standing Together will supply the management at each health site the necessary resource materials for the project. This will include:

- A full stock of leaflets.
- Publication ordering information from Women's Aid for the domestic violence leaflets and stickers.
- Paper and electronic copies of the screening protocols and any associated materials.

- Duplicate paper copies of the protocol resources (IPV assessment proforma, colour proforma flow charts, stickers for patient cards and protocol summary charts).
- The screening books will no longer be provided for Charing Cross A&E. Spare books will be passed to link nurse contacts at the WIC who wish to continue to conduct discrete monitoring.
- Electronic and paper copies of protocol training resource materials.
- Maintain referral route to ADVANCE.

It has been agreed that the management at the health sites will be responsible for purchasing and replenishing the domestic violence leaflets from Women's Aid directly, at an approximate cost of between £200 and £300 per year, when the existing supply runs out. Personnel at the health sites will also be required to monitor resources so they remain well stocked. A key person would need to be identified at each site for taking on responsibility for these tasks. The health project work will also feature on the Standing Together internet site www.standingtogether.org.uk

Maintaining the referral route to ADVANCE Advocacy Project

ADVANCE will continue to take telephone referrals generated from the health project. Attendance at Charing Cross Accident & Emergency Department to deal with referrals may have to be reviewed, depending on future workload and advocacy levels. ADVANCE will also ensure that sites are stocked up with sufficient supplies of ADVANCE leaflets. There is increasing pressure on ADVANCE due to an increase of referrals being made by the Police and cuts to the funding. It can no longer be presumed that ADVANCE can provide the health sites with an indefinite referral service without additional designated funding for health referrals.

Possible Future Work Areas

Developing computerised monitoring systems

Whilst it was disappointing that the Walk In Centre computer system could not be developed to contain a domestic violence screening field, the current development of the hospital's new computer system opens up new exciting horizons that may help to progress the mainstreaming aims of the project. It was originally hoped that work could be done with those designing the system to get a domestic violence screening prompt included. Although this has clear benefits for progressing routine screening, due to time constraints this was not possible. Further work on this would have to be conducted separately by A&E.

Child protection policy

Due to the statutory requirement of ensuring child protection, it has been agreed that the existing screening protocols will need to be amended, so that they adhere to the London Child Protection Committee Procedures. Standing Together therefore drafted a position paper on the protocols and child protection procedures, in conjunction with local child protection health professionals.

The Health Steering Group subsequently agreed to utilise this paper to aid discussions to clarify Child Protection policy. A&E and PCT representatives at the Health Steering Group have agreed to take this work forward within their departments. This will involve discussions with Social Services and the Area Child Protection Committee in order to resolve issues around policy, social services

notification/referral and intervention. Work on child protection and the screening protocols will therefore continue until the protocol adheres more closely with the current guidelines.

Institutionalising domestic violence training

A key aim of this health project is the negotiation of further training to embed and mainstream domestic violence interventions in a health care setting. Training key groups of practitioners on the issue of domestic violence would be an excellent undertaking for the future. These practitioners can then cascade the training to other staff as the need arises. The Health Steering Group has been very clear that this would only be effective if it is backed by referral routes to specialist domestic violence support services.

Standing Together is keen to see domestic violence incorporated in the training programme of the PCT. The recently published Public and Patient Involvement Strategy from the PCT outlines the aim of involving voluntary agencies in delivering TARGET training. It is hoped that regular funding will be made available by the PCT Training Department to fund domestic violence awareness training delivered by Standing Together to key PCT professionals such as Health Visitors and GP's. The PCT has agreed to fund one day's training in 2004/5 and this is a significant step forward for the health project.

The management at both Charing Cross A&E and the Walk In Centres agreed to have practitioners trained on how to train other staff on the screening protocol. This is a positive and significant step forward for the project as it demonstrated that management at the health sites have accepted and internalised the project. It also shows that elements of the projects mainstreaming aims are being achieved. This will help ensure that domestic violence interventions continue to be delivered at the health sites, and it also serves as an excellent professional developmental opportunity for the staff who agree to take on this extra responsibility.

It has been agreed that an experienced domestic violence trainer should always be utilised for domestic violence awareness raising training. This is necessary to ensure the safety of any survivors in the training room, allow for any professional dilemmas to be explored in a safe and productive environment, as well as explaining the complexities of this behaviour.

Due to funding difficulties after September 2004 health sites will need to raise funds to pay Standing Together and ADVANCE to deliver domestic violence awareness raising sessions. Training would be on the nature of domestic violence, as well as what is considered by the partners in Standing Together to be safe and well co-ordinated practice for all agencies in responding to those experiencing or perpetrating intimate partner abuse.

Embedding and Expanding Domestic Violence Screening Practices – What and Where Next?

The Hammersmith Hospital's Charitable Trust Amenities Committee has made a grant available to Standing Together, to maintain the project at the existing sites. Standing Together will continue to seek match funding to keep these sites on a stable footing. The Dr Edwards and Bishops Kings Fulham Charity has agreed to contribute to the project in 2004/5.

Charing Cross Hospital A&E Department have suggested expansion of domestic violence screening to Hammersmith Hospital which is in the same Hospital Trust and has a clear link through Mr Millington who is the A&E Consultant at both sites. Standing Together is particularly interested in

this possibility but this would only possible if adequate support was in place at the new sites and new funding was available.

The Health Steering Group have also expressed interest in expansion to new sites but this would only be possible following successful fundraising. The Children's Ambulatory Unit at Hammersmith Hospital, Midwifery Services at Queen Charlottes Hospital and Health Visitors are three areas that have been identified.

Recommendations for the Future

Following our involvement with the Health Service, Standing Together is extremely keen to continue this work in the future and to extend the remit of domestic violence interventions within a health care environment. Asking patients about domestic violence and offering help and referral to specialist support services, as we have demonstrated is welcomed and is a much needed service. To build upon this project's success to date we recommend the following steps are taken at both a local and a national level.

- Screening patients for domestic violence should become routine practice across the National Health Service, possibly located within specific health services such as GP's, midwifery, health visiting, Walk In Centres and A&E departments.
- A nationally implemented target to be introduced to ensure domestic violence screening occurs and that practice is routine, monitored, supported by management and has adequate resources attached to it.
- Each Primary Care Trust and Hospital Trust to have a domestic violence strategy which outlines good practice, referral routes and setting out staff roles and responsibilities in dealing with domestic violence.
- The Health Service to play an active role in local domestic violence forums. Domestic violence has a major impact on health and this is a key service that can and does improve safety for survivors. Health services are an important information and referral point.
- Training on domestic violence awareness and how it impacts on health should be compulsory for all health practitioners and professionals. Training should be designed and delivered in conjunction with local forums and domestic violence service providers and support agencies.
- Health services should have available to them a clear and high quality referral route, to refer patients on to when a disclosure of domestic violence is made.

Conclusion

We hope that this project and this report will add to the existing knowledge and research on the need, benefits and impact of health based domestic violence interventions. Standing Together is pleased that this project has proved to have had a significant impact in raising local interest in domestic violence services based within healthcare services. We hope that this interest can be pursued further with the Department of Health and that we will be able to share our experiences with other interested projects, in order to distribute and contribute to the development of good practice nationally.

In the future Standing Together will continue to look for funding to maintain the existing health sites, and with support from Midwifery Services at Queen Charlottes Hospital explore the prospect of a new domestic violence screening pilot project.

We also look forward to working with the Hammersmith and Fulham PCT to ensure the implementation and delivery of domestic violence training.

Full versions of the two screening protocols are available on the Standing Together web site www.standingtogether.org.uk

References

Why Mothers Die 1997 – 1999. The Confidential Enquiries into Maternal Deaths in the United Kingdom. (2001) Royal College of Obstetricians and Gynaecologists. RCOG Press. London

Sethi D, Watts S, Zwi A, Watson J and McCarthy C (2004) Experience of domestic violence by women attending an inner city accident and emergency department. Emergency Medical Journal 2004;21:180 –184.

APPENDIX ONE

Help Line Palm Card

Hammersmith and Fulham Local Resources

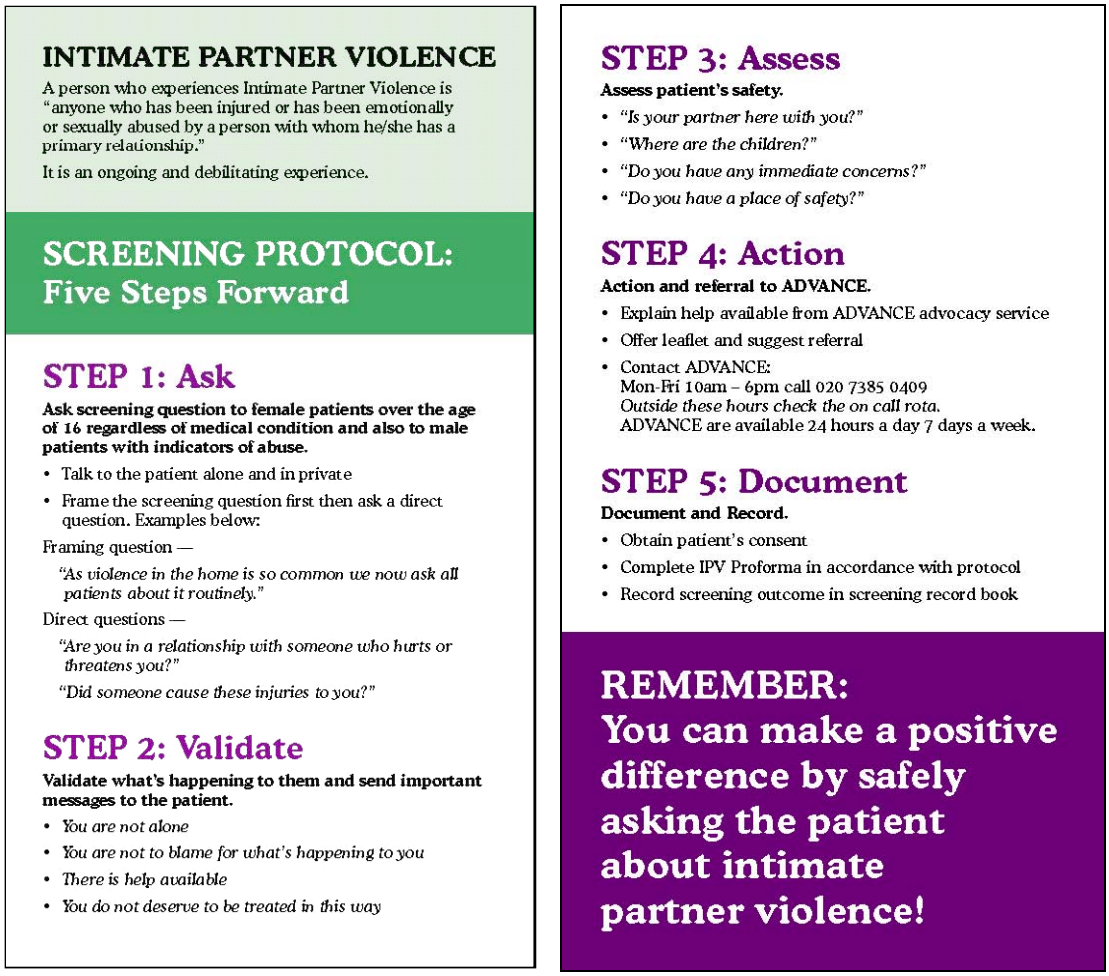
- Citizens Advice Bureau Fulham 0845 458 2515
- Council - switchboard 020 8748 3020
- Council - out of hours 020 8748 8588
- Emergency Housing - Daytime.....020 8753 4144
- H&F Community Law Centre 020 8741 4021
- H&F Police 020 8563 1212
- Shepherds Bush Advice Service 020 8753 5910
- Social Services (Children & Families) - Daytime 020 8753 5842
- Social Services - Emergencies after 6pm 020 8748 9787
- DVIP Women's Service.....020 8748 6512
- Victim Support 020 7385 6868
- Women's Aid - out of hours only 5pm - 9am 07949 127 617

London Wide Resources

- 24-hour National Domestic Violence Helpline - Freephone..... 0808 2000 247
- SOLA (DV help line for lesbians) 020 7328 7389
- Broken Rainbow (LGBT DV support) 07812644914
- NHS Direct (24 hours) 0845 4647
- NSPCC helpline (24 hours) 0808 800 5000
- Childline (24 hours)..... 0800 1111
- Police (emergencies)..... 999
- Refugee Council 020 7346 6777
- Samaritans (24 hours) 08457 909090
- Shelter Advice Line (24 hours)..... 0808 800 4444
- Women's Link (housing advice) ... ... .020 7248 1200

APPENDIX TWO

Protocol "Prompt" Card



INTIMATE PARTNER VIOLENCE

A person who experiences Intimate Partner Violence is "anyone who has been injured or has been emotionally or sexually abused by a person with whom he/she has a primary relationship."

It is an ongoing and debilitating experience.

SCREENING PROTOCOL: Five Steps Forward

STEP 1: Ask

Ask screening question to female patients over the age of 16 regardless of medical condition and also to male patients with indicators of abuse.

- Talk to the patient alone and in private
- Frame the screening question first then ask a direct question. Examples below:

Framing question —

"As violence in the home is so common we now ask all patients about it routinely."

Direct questions —

"Are you in a relationship with someone who hurts or threatens you?"

"Did someone cause these injuries to you?"

STEP 2: Validate

Validate what's happening to them and send important messages to the patient.

- *You are not alone*
- *You are not to blame for what's happening to you*
- *There is help available*
- *You do not deserve to be treated in this way*

STEP 3: Assess

Assess patient's safety.

- *"Is your partner here with you?"*
- *"Where are the children?"*
- *"Do you have any immediate concerns?"*
- *"Do you have a place of safety?"*

STEP 4: Action

Action and referral to ADVANCE.

- Explain help available from ADVANCE advocacy service
- Offer leaflet and suggest referral
- Contact ADVANCE:
  Mon-Fri 10am – 6pm call 020 7385 0409
  Outside these hours check the on call rota.
  ADVANCE are available 24 hours a day 7 days a week.

STEP 5: Document

Document and Record.

- Obtain patient's consent
- Complete IPV Proforma in accordance with protocol
- Record screening outcome in screening record book

REMEMBER: You can make a positive difference by safely asking the patient about intimate partner violence!

This laminated Protocol 'prompt' Card has been created by Standing Together and is given to staff following their attendance at the screening protocol training as part of their information packs.

APPENDIX THREE
Domestic Violence: An Important health issue - training objectives

HEALTH PROJECT
DOMESTIC VIOLENCE:
AN IMPORTANT HEALTH ISSUE

TRAINING OBJECTIVES

During the session we aim to:

1. Inform participants about key aspects of domestic violence: its scale, seriousness and effects, including the effects on Survivors' ability to recognise and talk about what is happening.

2. Enable participants to reflect on the implications for their practice as health professionals.

3. Discuss some practical ways of prioritising safety for survivors, and for staff.

4. Inform participants about survivors' perceptions including their views of health service screening, and how these inform the work of Standing Together.

APPENDIX FOUR
Intimate Partner Violence Screening Protocol - training objectives

HEALTH PROJECT

INTIMATE PARTNER VIOLENCE PROTOCOL:

SCREENING, DOCUMENTING AND MAKING REFERRALS

TRAINING OBJECTIVES

During the session we aim to:

1. Introduce health staff to the amended Protocol (2003) for handling cases of Intimate Partner Violence, and their specific roles in carrying out the Protocol.

2. Provide information about why, how, when and of whom to ask the initial screening questions that can assist disclosure of abuse from an intimate partner.

3. Clarify how to assess immediate danger and respond to the patient.

4. Review how to document cases after screening.

5. Inform participants about the actions they can/should take if patients disclose domestic violence to them: in particular some key sources of help for survivors including from ADVANCE advocacy project; and the support staff can expect from ADVANCE.

6. Consider ways of making this process as safe as possible for patients and staff.

APPENDIX FIVE
Intimate Partner Violence Assessment Proforma

INTIMATE PARTNER VIOLENCE ASSESSMENT PROFORMA IPV1

BASIC INFORMATION

1. Date:_____

2. Patient Name:_____

3. Is patient pregnant ___Yes ___No

4. How did the injuries occur? (try to use patient's own words)

_____

_____

_____

5. Is assaulted, what is the patient's description of the assault? (example- struck with ?sts or object, kicked, thrown)

_____
_____
_____
_____
_____

6. Does the patient allege intimate partner violence/domestic violence?
___Yes ___No

7. If yes,
   a. the name of the alleged assailant

_____

   b. the relationship to the patient

_____

SAFETY PLAN

Assess Patient Safety

___Yes ___No Is your partner with you today?
___Yes ___No Are you afraid to go home?
___Yes ___No Has abuse increased in frequenc over the last year?
___Yes ___No Does your partner threaten to harm you or him/herself?

What are you most concerned about?

*(*Note for indications that the patient might leave ea and make sure you have given referral information.)*

Review Patient Referrals

We can call a service called ADVANCE to speak with you now or to set up an appointment for later.

___Yes ___No Would you like me to call ADVANCE now?

Would you rather me contact ADVANCE and ask them to call you at a certain time? If yes ?ll in below:

Day of week:_____
Good time to call:_____
Number to call:_____

___Yes ___No Resource materials given

___Yes ___No Does the patient want to call the Police?

Has the patient talked with any other agencies about abuse in the past? (If yes, which ones?)

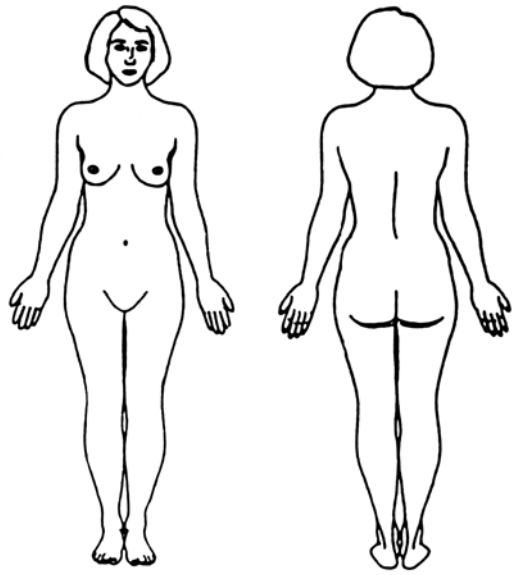
Signature of Nurse:_____ Date:_____

DOCTORS - FILL IN THIS SIDE

Physical findings for intimate partner violence:

Notes:

Indicate where injury was observed:



	Bruise	Abrasion	Laceration	Bleeding	Tenderness
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

Consent for photographs given by patient: (patient signature) _____

Photographs taken __ Yes __ No

Signature of Doctor: _____