Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

GP Domestic Abuse & Sexual Violence Policy Toolkit

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Policy Toolkit

This policy toolkit has been designed to enable GP practices to implement their own comprehensive domestic abuse and sexual violence policy, covering both staff and patients affected by domestic abuse and/or sexual violence.

The toolkit contains an exemplar policy along with guidance notes which explain why the policy has been written in the way it has. This is to enable considered decisions to be made about changes and edits you may wish to make to your practice policy.

The policy is open to personalisation, but careful consideration should be given to the guidance notes before making changes. When adding your own practice branding to the policy, please retain the footer which states that the policy originated from HWE ICB. This will make it easier for colleagues to know where to direct any questions they have about it.

If you have queries, you can contact either the ICB Safeguarding Teams by emailing hweicbhv.safa@nhs.net or hweicbenh.sgclac@nhs.net or the Named GPs for Safeguarding Children.

A Whole Practice Approach to Domestic Abuse & Sexual Violence

Having a comprehensive domestic abuse and sexual violence policy is a vital component of creating a whole practice approach, but it is only one component.

A policy that isn't translated into practice, will not make a difference to staff or patients affected by domestic abuse and/or sexual violence It is equally important that practice staff have a good level of understanding of domestic abuse and sexual violence and feel confident and competent to respond.

Alongside a policy, it is recommended that each practice.

- Identify a domestic abuse and sexual violence (DASV) lead for the practice (this may be your Children or Adult Safeguarding Lead) who will drive improvements in the response to staff and patients affected by these issues.

- Enable the DASV lead to access regular training updates and has mechanisms through which to share learning with colleagues

- Train all staff in domestic abuse and sexual violence identification and response to a level that fits with their job role and responsibilities for patient care and staff management.

- Make visible within the building information in the form of posters, leaflets and TV screens, on domestic abuse and sexual violence and how to seek help. Consider your patient population and the need for literature in different languages and in easy read formats.

- Make visible on your website information about domestic abuse and sexual violence and how to seek help.

  The ICB can support you with accessing appropriate training, leaflets and posters. Please contact the Adult Safeguarding Team hweicbhv.safa@nhs.net if you have a request.

Key Principles

There are key principles underpinning the exemplar policy. Before making changes to the policy, consider whether they are consistent with these principles.

1. A proactive approach

Some patients will seek support for DASV from healthcare practitioners, many others do not disclose unless asked about their experience. Harm can be mitigated by early intervention and enquiry creates opportunity for that early intervention. The DASV policy should outline the proactive steps staff will take.

2. No ‘them and us’

Domestic abuse and sexual violence are issues affecting all parts of society. Education, professional role or status does not create immunity from abuse. Many people working within health services, have experienced DASV. If the DASV policy does not explicitly include staff members, it can create an unhelpful perception that DASV ‘doesn’t happen to people like us’

3. An inclusive approach

Marginalised groups encounter additional barriers to disclosing DASV and to accessing support. The DASV policy must consider the need to reach out to marginalised groups, rather than assume the needs of every patient or staff member will be the same. Consider the needs of your local population. The DASV policy must link to your safeguarding adults’ policy.

4. A whole family approach

DASV affects children as well as adults, The Domestic Abuse Act (2021) recognises children as victims of domestic abuse in their own right. The DASV policy must link to your child safeguarding policy. The DASV policy should outline the role of the practice in supporting or making referrals for children who do not meet thresholds for local authority intervention. The policy should also include identifying and responding to perpetrators of domestic abuse.

5. Trauma led approach.

Sexual violence is often a feature of domestic abuse, but it also occurs outside of intimate relationships. The DASV policy should outline the practice response to all forms of sexual violence and abuse, whether in the context of domestic abuse or not.

Hertfordshire and West Essex Integrated Care System

Essex County Council

Hertfordshire

NHS

Policy with Guidance

Policy Template for Domestic Abuse & Sexual Violence for Hertfordshire General Practices

Name of Practice:	
Date Approved:	
Version:	
Revision Date:	
Accountable GP:	
Practice DASV Lead:	

Guidance Notes
There are comments throughout the policy explaining why the policy has been written in the way it has.

This policy includes domestic abuse and sexual violence. Sexual violence that occurs outside of an intimate relationship is not consistently identified in primary care, despite the prevalence rates.

We suggest you identify a DASV lead to take responsibility for policy revision.

Policy on a Page

Practice Name:

GP Domestic Abuse & Sexual Violence Policy Toolkit

Why do we need this policy?
Domestic abuse and sexual violence are highly prevalent and can be experienced by anyone. It happens in all communities, regardless of gender, age, disability, gender identity, race, religion or belief, sexual orientation, marriage or civil partnership and pregnancy.

This policy is intended as a resource for all staff working at the practice. It outlines the duties, roles and responsibilities, that practice staff have in responding to domestic abuse and sexual violence, be it in relation to a patient or to a colleague.

Practice Domestic Abuse Lead and Deputy Domestic Abuse Lead:

What do I need to do?

- make yourself familiar with the DASV policy.
- undertake any training offered in DASV.
- know what the practice can do to support you if you are affected by DASV.
- apply your learning to recognise signs and symptoms in colleagues and patients.
- enquire sensitively and provide a non-judgemental and empathetic response
- understand the practice's process for responding to disclosure and know what to do when there is immediate risk of harm to adults or children.
- know who the DASV lead is for the practice and what further support is available if needed.

Where can I refer and get support for victims of Domestic Abuse or Sexual Violence?
Adults: section 7.3,
Children and Young People: section 10.1

Where can I refer and get support for Perpetrators of DA? Section 9

Where can I get support for myself? Section13

Who does it affect?
This policy is applicable to all staff working for, or on behalf of the practice which includes all bank, agency and volunteer staff.

Where can I find more information?

Herts Sunflower

Herts Domestic Abuse Helpline
08 088 088 088

Hertfordshire Domestic Abuse Helpline

See appendix 3 for a range of support services

Who can I contact?
Hertfordshire Independent Domestic Violence Advisor (IDVA) Service
IDVA office duty: 0300 790 6772
Out of Hours: 0800 328 7760 5pm-9am Mon-Fri, all day weekends
Email: hertsidva@refuge.org.uk

For Children
Named GP for Safeguarding Children

ICB Safeguarding Teams
Adult Safeguarding Team hweicbhv.safa@nhs.net
Tel.: 01442 898 888
Children's Safeguarding Team hweicbenh.sgclac@nhs.net
Tel: 01707 685000

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1. Purpose

This policy is intended as a resource for all staff working at the practice. It outlines the duties, roles and responsibilities, that practice staff have in responding to domestic abuse and sexual violence, be it in relation to a patient or to a colleague.

The policy outlines the support a staff member can expect to receive if they are affected by domestic abuse or sexual violence (DASV).

The policy has been developed with the benefit of learning from Domestic Homicide Reviews (DHRs), national policy recommendations and guidance such as NICE guidance.

To be comprehensive, the policy must address; staff members concerned about a patient, staff members concerned about a colleague and staff members concerned for themselves.

2. Scope

Domestic abuse and sexual violence are highly prevalent and can be experienced by anyone. It happens in all communities, regardless of gender, age, disability, gender identity, race, religion or belief, sexual orientation, marriage or civil partnership and pregnancy. Some people will find it harder to report DASV or access support because of systemic, societal barriers linked to their identity. This policy outlines the steps practice staff will take to create equity.

Clinical and non-clinical staff alike are in a potential position to identify and respond to DASV. It is essential therefore that all staff members have read the DASV policy and understand their potential role in supporting people affected.

Anyone in the practice, irrespective of job role, may have opportunities to identify and respond to a patient or colleague needing support.

All staff should be aware of this policy and act accordingly through the management structure to respond to suspicions of, or actual DASV experienced or perpetrated, whether in relation to patients or colleagues. The policy sets the parameters for this and should be read alongside related policies including:

We know that older people, people who identify as Lesbian, Gay, Bisexual or Transgender, those with learning disabilities, with mental health problems, from minoritized ethnic groups, and those using substances, are less likely to be identified and supported and are therefore at risk of experiencing abuse for increased duration and severity.

Adult safeguarding policy
Child safeguarding policy

We suggest that you list your related policies in this section and add a hyperlink

The DASV policy recognises that everyone has a right to live free from fear and abuse. Early intervention can reduce the impact of DASV on health.

……. (insert practice name) will ensure that victims of domestic abuse and/or sexual violence will receive a high standard of care irrespective of gender, age, disability, gender reassignment, race, religion or belief, sexual orientation, marriage or civil partnership and pregnancy.

…….. (insert practice name) will promote the importance of responding appropriately to people perpetrating domestic abuse or sexual violence.

……. (insert practice name) will ensure that the policy will be applied to both patients and to staff employed by the practice.

3. Definitions

a) This policy adopts the 2021 Domestic Abuse Act definition of domestic abuse:
Any incident or pattern of incidents of physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic abuse, psychological, emotional, or other abuse between those aged 16 and over and personally connected to each other.

A personal relationship between the victim and perpetrator is key to the definition of domestic abuse. The act defines people who are 'personally connected' as: intimate partners, ex-partners, family members or individuals who share parental responsibility for a child. There is no requirement for the victim and perpetrator to either still be in a relationship live in the same household.

The act recognises post-separation abuse through coercive and controlling behaviour.

The act also recognises children as victims of domestic abuse. This is the first time that a child who sees or hears, or experiences domestic abuse, and is related to the person being abused or the perpetrator, is also to be regarded as a victim of domestic abuse in their own right. The impact of domestic abuse can range from loss of self-esteem to loss of life.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'

The Government definition, which is not a legal 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.

Intrafamilial abuse means any abuse that occurs within a family context by a parent, child, stepparent, guardian, legal custodian, a relative, or a spousal equivalent, or by any other person who resides in the home. This may include abuse of adults by their children, including adult children.

b) This policy adopts the World Health Organisation definition of sexual violence.

"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person

Your policy should have clear definitions of domestic abuse (including a description of coercive control) and of sexual violence. Definitions should be taken from nationally recognised and reputable sources.

This is a broad definition, enabling your staff to consider all forms of sexual abuse and violence.

regardless of their relationship to the victim, in any setting, including but not limited to home and work

Coercion can encompass varying degrees of force; psychological intimidation, blackmail; or threats (of physical harm or of not obtaining a job/grade etc.). In addition, sexual violence may also take place when someone is not able to give consent – for instance, while intoxicated, drugged, asleep or mentally incapacitated"

Sexual violence can occur both within and outside of the context of domestic abuse.

4. The Practice DASV Lead

Each GP practice should have its own DASV lead. This may be within the responsibilities of your safeguarding lead.

The DASV lead is……
The deputy DASV lead is…….

The DASV lead will:

- have in-depth knowledge and understanding of both domestic abuse and sexual violence referral pathways, risk assessment and the support services available.
- will engage in additional training and learning to be able to lead the practice response to DASV.
- ensure that the practice staff are appropriately trained.
- regularly review the DASV policy
- regularly review DASV information on the practice website and on display within the surgery to ensure it is current.
- provide guidance and support for staff.
- support staff in referring to the Hertfordshire Independent Domestic Violence Advocacy (IDVA) service
- support staff to participate in MARAC (Multi-agency Risk Assessment Conference) where appropriate
- ensure that child protection and adult safeguarding procedures are initiated where necessary.
- take proactive steps to increase awareness and knowledge of DASV amongst colleagues and patients.

5. The Role of the Primary Healthcare Team

Research shows that many people experiencing DASV present to their GP and that by offering support earlier, the health impacts of DASV can be reduced. Some staff, because of their clinical role, will have additional opportunities and responsibilities.
All staff will.

- make themselves familiar with the DASV policy.
- know what the practice can do to support them if they themselves are affected by DASV.
- undertake any training offered in DASV.
- apply their learning to recognise signs and symptoms in colleagues

The ICB Adult Safeguarding Team can help you identify sources of further training and information to support your role.

We suggest you insert the name and contact details of your practice DASV lead here.

Training packages should cover:

- the health markers of domestic abuse and sexual violence (see examples in appendix 1).
- How to 'ask the question' sensitively and how to create a safe space for disclosure.
- How to manage disclosures sensitively.
- The implications of domestic abuse for both child protection and adult safeguarding.
- How to respond in cases of immediate and significant risk.
- How to document DASV and manage patient notes safely.
- The protocols of information sharing, consent and confidentiality.
- Local DASV response pathways for all levels of risk.
- The practice's process for responding to disclosure of domestic abuse or sexual violence. (see example in appendix 2).

What to do when a perpetrator discloses or is also registered with the GP.

The practice DASV lead should plan annual DASV inputs to give staff a refresher. If you have IRIS, they will provide refresher training.

and patients.
- enquire sensitively and provide a non-judgemental and empathetic response
- understand the practice's process for responding to disclosure and know what to do when there is immediate risk of harm to adults or children.
- know who the DASV lead is for the practice and what further support is available if needed.

In addition, clinical staff will:

- recognise patients whose symptoms may be indicative of trauma due to DASV.
- document domestic abuse and sexual violence within patient records safely, with awareness of patient access to their records and the risk this may pose and keep records for evidence purposes.
- know how to refer to the IDVA Service
- contact the police and the IDVA Service if the patient is in immediate danger, and it is not safe for them to return home
- know how to share information appropriately.

If you need support to fulfil your responsibilities, contact the practice DASV lead.

6. Training

All staff should undertake training in recognising and responding to DASV.

In accordance with the NICE guidelines for domestic violence and abuse (https://www.nice.org.uk/guidance/ph50), clinical staff should be,

"trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. This involves an understanding of the epidemiology of domestic violence and abuse, how it affects people's lives and the role of professionals in intervening safely. Staff should also be able to respond with empathy and understanding, assess someone's immediate safety and offer referral to specialist services".

Once trained, staff should attend annual updates.

7. DASV Clinical Enquiry Process

The next sections of the policy set out the process for clinical enquiry and the responses that should follow. This is also captured in the flow chart (appendix 2)

7.1 Clinical Enquiry

Some medical presentations may be indicative of a patient experiencing domestic abuse or sexual violence. These signs can help staff identify specific patients to ask about DASV. See appendix 1.

However, in many cases the indicators are subtle or ambiguous. All clinical staff should therefore set a low threshold for enquiry, demonstrating professional curiosity and asking a broad range of patients.

Professional curiosity is required to support practitioners to question and challenge the information they receive, identify concerns and make connections to enable a greater understanding of a person's situation.

Research shows that survivors of domestic abuse and sexual violence do want to be asked. Simple, sensitive but direct questions can enable disclosures. There is strong evidence to support the policy of asking about DASV within general practice.

Patients should be asked both,

- whether they are *currently* experiencing DASV
- whether they *have in the past* experienced DASV.

There are many ways in which to enquire and the most appropriate wording will depend on the patient and the circumstances. Examples include:

- Does anyone at home make you feel scared?
- It's not uncommon for patients with these symptoms to be experiencing abuse from someone, is everything okay at home?
- Because domestic abuse & sexual violence are common, I like to ask my patients if that's something that's happened to them…
- Sometimes patients who have these injuries have been hurt by someone, has that happened to you?
- Has anyone hurt you or threatened to?
- Do you feel controlled or isolated?
- Is anyone controlling or belittling you?
- Are there times when sex is unpleasant or painful?
- Has your partner ever forced or pressured you into doing things that you weren't comfortable with? What were they?
- Do you ever feel you have to have sex when you don't want to?
- Have any of these things happened to you previously?

Research shows that there is considerable unmet need amongst patients who have experienced trauma

Past experiences of trauma are associated with some health conditions and the patient may need ongoing support.

Patients should only be asked about DASV when they are on their own for safety reasons. This includes not asking in front of children over the age of 2 and family members. For video or telephone consultations, it's important that you check with the patient that they are alone.

For further guidance on asking about DASV remotely see IRIS's guidance https://irisi.org/wp- content/uploads/2020/06/IRISi-COVID-19-Doc-and-info-sheets-11.pdf

Staff are encouraged to remember that success is enquiring in a safe way, no matter what the response or what help is accepted by the patient. It may take multiple consultations or enquires before a patient feels able to disclose and it is important to ask more than once. This sends a strong message to the patient that domestic abuse and sexual violence are serious. Just asking may change the patient's thinking about what is happening to them. It also sends the message that there is help available. The patient may not accept help on the day but may keep the local resource numbers and call for help in the future.

When enquiring, staff should be aware of how to respond to disclosures and what steps to take, including the safeguarding considerations. See appendix 2 for a care pathway.

Opportunities for Clinical Enquiry

There are routine appointments which present an opportunity for clinical enquiry. It is recommended that you include a prompt to clinicians to consider clinical enquiry for DASV when patients attend for:

- new patient checks
- annual health checks for adults and young people aged 14 or over with a learning disability.
- contraception checks
- post-natal checks
- cervical smear tests
- consultations about mental illness or dementia
- carers assessment or conversations about caring role

New patient registration forms should be adapted to allow patients to confidentiality indicate that they are residing in a refuge or a safe house. This information should be relayed to the GP and to your safeguarding lead. This will alert the practice that the new patient has experienced high levels of domestic abuse which has caused them to seek refuge. The GP should contact the patient to acknowledge the information shared with the practice and to discuss any related health concerns the patient has.

Pregnancy

There are well evidenced DASV risk factors associated with pregnancy and these risks can continue for the first year or so after the baby is born.

All pregnant women should be asked if they are experiencing DASV throughout their pregnancy and at post birth appointments. Whilst midwifery and health visitor colleagues are also expected to enquire, the opportunity of early identification is increased if a range of practitioners are asking.

For any pregnant patient, where DASV is disclosed or known to be pre-existing, the midwifery team must be informed so that they can offer appropriate support and pre-birth planning. Prebirth or antenatal referral to the MASH team should be considered. The local hospital, midwives or GP must be informed promptly.

Clinicians should consider referral to the IDVA Service for pregnant patients where DASV is disclosed or is a known to exist.

If staff are unable to enquire with a patient where enquiry appears appropriate; for example, if they are accompanied to the appointment and cannot be separated, then this should be recorded in the patient record.

7.2 Risk Assessment

Domestic abuse can lead to homicide. On average 2 women a week in England and Wales are killed by a partner or ex-partner.

There are a number of indicators that someone is at high risk of domestic homicide. These are captured in the Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) checklist which can be found here: https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf

The IDVA Service will complete a DASH assessment. This will give staff an indication of the risks to the patient. Steps to address those risks must also be taken. These will include

- safety planning discussion with the patient
- referral to a specialist support service
- referral to MARAC if threshold reached
- referrals to MASH or adult safeguarding services if appropriate

If there are immediate safety concerns and the patient is not safe to return home contact the police and the IDVA service for advice (see appendix 3).

If sexual violence is disclosed, also follow the guidance outlined in section 7.3

We recommend that you edit this line to reflect what resource you have available in your practice

7.3 Response

All disclosures

Listen, try to understand and take care not to blame the person making the disclosure. Tell them that they are not alone and that there are many people like them in the same situation. Acknowledge that it takes strength to trust someone enough to talk to them about experiencing abuse. Give them time to talk, but don't push them to go into too much detail if they don't want to. Acknowledge that they are in a frightening and very difficult situation.

It is important that someone making a disclosure is not forced to act. People who have experienced abuse are best placed to understand how to protect their safety. Taking action, such as planning to leave, can put the person in greater danger.

Do not inform the perpetrator of the disclosure as this may also increase the risk to the patient.

All patients should be offered safety planning advice.

Safety planning should involve discussing with the patient the options available to them to increase their immediate safety, and that of their children.

- offer to make a referral to the IDVA service or provide the details so they can self-refer when they are ready.
- explain that the IDVA service is a confidential and independent support service who can provide specialist support & advice"
- encourage the patient to call 999 if they are threatened or feel in danger
- discuss storing domestic abuse helpline numbers on their phone discreetly under a false name.
- ask whether they feel safe to return home or whether they can stay somewhere else

- ask if they are considering leaving. This is a high-risk time. Stress to the patient that it's important to get the support of a domestic abuse professional who can help them make a plan to leave safely.
- discuss whether they have access to a mobile phone with good signal and battery
- ensure the patient's phone is switched off when interviewing the patient in case their phone is being monitored by the abuser.
- ask if there are times when the abuse or violence is more severe, for example when their abuser has been drinking. Explore what options they have to avoid being alone with that person at that time.
- check that they know how to delete their browser history and phone messages if they are concerned that their abuser may be checking their devices.
- ask if there are trusted family/friends/neighbours they could talk about the abuse and could go to in an emergency?
- advise the patient to dial 999 if they are in danger and press 55 if they are unable to speak
- ask if it would be useful to have additional appointments or calls with the GP practice so that they have contact with someone until longer term support is put in place.

If sexual violence is disclosed

It is important that this is responded to promptly and that patients are referred to the correct services. They are likely to have physical as well as emotional trauma. There is a short forensic window within which evidence can be secured. Whilst patients may not want to consider or discuss criminal proceedings in the immediacy of a sexual assault, securing the evidence provides them with more options at a later stage.

If the assault happened in the last 10 days, refer to the Sexual Assault Referral Centre (SARC). This must be done immediately. See https://www.hertssarc.org/ for information on the SARC and how to refer. The Sexual Assault Referral Centre (SARC) is specifically designed to meet the needs of children and adults who have experienced rape and sexual assault. The SARC offers medical, practical and emotional support. They have specially trained NHS doctors, nurses and support workers who will explain to the patient the options available and who will work at their pace. Patients can also self- refer. They will be offered a forensic medical examination (if applicable), assessment, medical treatment, sexual health advice and emergency contraception to prevent pregnancy.
They can also arrange for the patient to speak informally with a specially trained police officer to help them consider options for reporting to the police. Independent Sexual Violence Advisors (ISVA) will offer support and access to counselling.

The SARC can be called for advice on 0808 178 4448
If the assault happened recently, but more than 10 days ago, the SARC can still offer support, but will be unable to gather forensic evidence.

Outside of the forensic window people can still receive support from and Independent Sexual Violence Advisor through the SARC.

If domestic abuse is disclosed:

You should make the referral to the IDVA Service and highlight to them any risk indicators that you've become aware of. If you are very concerned, call support services whilst the patient is present in the practice and ask that they speak with them directly.
The IDVA service needs the patient's consent to make contact with them. If the patient does not consent the IDVA Service can still offer advice to the professional.

7.4 Recording

Record the patient's disclosure using their own words. Place a copy of the referral paperwork in the patient's record and document any actions taken and advice given.

It is important to record DASV on patient medical records. This information can help inform risk assessments, safeguarding and safety planning with patients.

Ensure that information is recorded safely, with awareness of patient access to their records. This information must be hidden from patient online access as 'sensitive and third-party information' as this record may be seen by the perpetrator and escalate the abuse.

Do not record in the perpetrator's record unless they have disclosed this information themselves.

Full guidance on how to record domestic abuse on the patient's EMR is detailed in the 2021 RCGP *Guidance on recording domestic abuse in the electronic medical record.*

8. Information sharing

The Caldicott guardian principles to domestic violence *Striking The Balance* provides guidance on information sharing in the context of high risk domestic abuse https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215064/dh_133594.pdf

8.1 Multi-Agency Risk Assessment Conferences (MARAC)

Patients and staff identified to be at risk of domestic homicide must be referred to the local Multi-Agency Risk Assessment Conference, this will be completed by the IDVA Service. Practitioners can also refer directly to MARAC if they feel a patient is at high risk of further abuse or homicide (see appendix 7). MARAC is a process through which information on families at risk of domestic homicide is shared amongst professionals and an action plan to mitigate those risks is produced.

The primary focus of the MARAC process is to safeguard the adult victim and to prevent domestic homicide. The MARAC will also make links with others to safeguard children and manage the behaviour of the perpetrator. MARAC is based on the principle that no single agency or individual can see the complete picture of risk to a family, but all may have insights that are crucial to safety. The family does not attend the meeting, but the adult victim is represented by an Independent Domestic Violence Advisor (IDVA) who speaks on their behalf.

Any frontline agency representative that undertakes a risk assessment and thereby determines that their case meets the high-risk threshold, can refer a case to a local MARAC. Intervention by a MARAC and an IDVA service has been shown to be highly effective in increasing safety for people experiencing domestic abuse.

Short training films on MARAC: https://safelives.org.uk/practice-support/resources-marac-meetings/marac-videos

More information on MARAC:
https://safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf

If a patient on your list is referred into MARAC, you may be asked to provide information relevant

to risk and safety. GPs may hold information that other services do not which could be crucial for a robust risk assessment and action plan. The request will come from the MARAC administrator or coordinator, based within the Hertfordshire Police.

The practice DASV lead or the ICB Safeguarding teams can offer advice on appropriate information sharing with MARACs.

It is also recommended that the MARAC guidance for GPs is read. This contains detailed guidance on recording MARAC in patient files:
https://safelives.org.uk/sites/default/files/resources/Multi-Agency%20Risk%20Assessment%20Conference%20Guidance%20for%20GPs_0.pdf

You may be invited to attend the MARAC meeting to share the information in person or on a virtual platform.

You may be sent information about a patient who has been discussed at a MARAC meeting. It is vital that this sensitive information is managed and recorded carefully.

The MARAC administrator or coordinator can answer queries about information sent to the practice. See section 7.4 for recording guidance.

8.2 Domestic Homicide Reviews (DHRs)

A Domestic Homicide Review (DHR) is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Since 13 April 2011 there has been a statutory requirement for local areas to conduct a DHR following a domestic homicide that meets the criteria.

The purpose of a DHR is to;

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- contribute to a better understanding of the nature of domestic violence and abuse.
- highlight good practice.

It is often the case that people experiencing domestic abuse and/or people perpetrating domestic abuse are known to general practice. GPs may be called upon to provide a report. It is important that this is provided to the review panel with a comprehensive chronology of involvement with the victim and others that may be the subject of the review. This will allow the review panel and chair

to fully analyse events leading up to the homicide.

The ICB Safeguarding Teams can give guidance to GPs who receive requests for information in relation to a DHR hweicbhv.safa@nhs.net or hweicbenh.sgclac@nhs.net

For more information see: the Home Office *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* (2016) *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf*

And

the Department of Health document '*Striking the Balance' (*2012) *https://www.gov.uk/government/publications/striking-the-balance-practical-guidance-on-the-application-of-caldicott-guardian-principles-to-domestic-violence-and-maracs-multi-agency-risk-assessment-conferences*

8.3 Legal Aid

Many victims of domestic abuse apply for civil orders to improve safety for themselves and their children. This can be very costly and without legal aid, some individuals are not able to seek legal remedies. Civil legal aid is only available for family matters where an individual can prove they are a victim of domestic violence. One of the routes to provide evidence is via the individual's doctor.

The Domestic Abuse Act 2021 prohibits GPs and other health professionals from charging a victim of domestic abuse for a letter to support an application for legal aid. https://www.bma.org.uk/pay-and- contracts/fees/fees-for-doctors-services/fees-for-legal-aid-evidence-from-victims-of-domestic-violence

9. Those who use abuse or controlling behaviours

Perpetrators of domestic abuse and of domestic homicides are also patients. Local Domestic Homicide Reviews have shown that some patients perpetrating domestic abuse have approached their GP for support. It is important that staff act when there are concerns.

Clinicians should consider:

- patients disclosing 'anger management problems' or 'arguments' at home which may be an indirect way of seeking help for abusive behaviours.
- patients disclosing feelings of jealousy, paranoia, low mood or anxiety.
- patients saying that their partner, friends or family have encouraged them to seek help from the GP because of their moods or behaviour.

Clinicians should ask gentle, exploratory questions about the patient's relationships, their mental wellbeing and how they manage conflict. These can lead to more direct questions about whether they are concerned about their own behaviour to others.

Patients should be encouraged to contact the Hertfordshire Change Project, a domestic abuse prevention programme for people who want to improve the way they behave in relationships, or the Respect helpline on 0808 8024040 or visit: www.respectphoneline.org.uk.

If the patient disclosing has a partner who is registered at the practice, notify the partner's GP that a clinical enquiry for DASV would be appropriate with that patient. This gives opportunity for the patient at risk to disclose and to seek support. It is essential that patient confidentiality is protected. The partner thought to be at risk should not be told that the clinical enquiry is linked to disclosures received.
In circumstances where there are concerns that the person presents a serious risk to themselves or others, information may need to be shared in order to safeguard the patient or others. Speak with the practice DASV lead or the ICB Safeguarding Teams for guidance.

If a member of the practice staff is arrested, cautioned or prosecuted for an offence related to domestic abuse or sexual violence, managing allegation protocols should be followed.

See also section 13 support for employees.

10. Children and Young People

10.1 Domestic abuse

There is evidence that children living in a household where domestic abuse is taking place suffer long-term harm. It is estimated that one in five children grow up experiencing domestic abuse. The Domestic Abuse Act 2021 recognises children as victims in their own right.

Follow child protection procedures. If a referral to MASH is not appropriate, refer or signpost to support services such as

- Your IRIS worker (who can support the parent)
- Local domestic abuse services (who may have a children's worker)
- Early Help
- CAMHS

There are self-help resources.

For parents:
- Young Minds: https://youngminds.org.uk/find-help/for-parents/parents-guide-to-support-a-z/parents-guide-to-support-domestic-violence/
- Refuge: https://www.refuge.org.uk/get-help-now/support-for-women/what-about-my-children/

For children and young people:
- The Hideout: https://thehideout.org.uk/
- ChildLine: https://www.childline.org.uk/info-advice/home-families/family-relationships/domestic-abuse/

- Children and young people who have experienced domestic abuse may act out and show aggression. Children and young people using harmful behaviours is a child safeguarding concern. It can be an indicator or underlying distress or trauma.

There are self-help resources for parents.
- Family Lives: https://www.familylives.org.uk/advice/teenagers/behaviour/teen-violence- at-home/
- Holes In The Wall: https://holesinthewall.co.uk/resources/leaflets-and-information-for-parents/

10.2 Young People in Abusive Intimate Relationships

Young people are particularly at risk of intimate partner abuse and sexual violence. The cross-Government definition of domestic violence and abuse was changed in 2013 to encompass 16- and 17-year-olds, in recognition that 16-19-year-olds were the group most likely to suffer abuse from a partner. Additionally, young people in abusive intimate relationships have been shown to experience particularly high levels of sexual violence from their partners.
The IDVA Service can complete a Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) checklist with young people, age 16 and above who disclose that they are in an abusive intimate relationship (see 7.2 for more detail on the DASH).

The standard version of the DASH can be used, however there is also a young person's version with added guidance for responding to this age group.

Young Person's DASH
https://safelives.org.uk/sites/default/files/resources/YP%20RIC%20guidance%20FINAL%20%281%29.pdf

For children under 16 years of age make a Children's Safeguarding referral.

10.3 Sexual Violence and Abuse

24.1% of young adults report some form of sexual abuse in their childhood[1]. All professionals need to be alert to the indicators of sexual abuse, act on their concerns and follow their child safeguarding procedures.

The Sexual Assault Referral Centre provides forensic medical assessments for children and young people from following sexual assault, both recent and non-recent (more than 10 days)

See https://www.hertssarc.org/ for information on the SARC and how to refer.

Here are resources for parents

24.1.1 MOSAC for parents whose children have been sexually abused: https://www.mosac.org.uk/
24.1.2 NSPCC helplines https://www.nspcc.org.uk/keeping-children-safe/reporting-abuse/dedicated- helplines/
24.1.3 ChildLine have a webpage specifically for children and young people who have experienced sexual violence and abuse.
24.1.4 ChildLine https://www.childline.org.uk/info-advice/bullying-abuse-safety/abuse-safety/sexual- abuse/

10.4 Adolescent to parent violence and abuse (APVA)

While domestic violence between adults in the UK is generally well recognised, child to parent violence and abuse in families often remains hidden and unacknowledged because of the shame associated with it and the fear of what could happen if it is reported.
It exists across all communities, social classes, cultural background and geographic area.
There is currently no legal definition of adolescent to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse and, depending on the age of the child, it may fall under the government's official definition of domestic violence and abuse (if child > 16 years old).

[1] NSPCC Maltreatment Survey, Radford 2011

The mother is likely to be the recipient of APVA. Lone parents, parents facing significant social and family stressors are more likely to experience abuse from their children.
It is important to recognise that APVA is likely to involve a pattern of behaviour, which can include physical violence, emotional abuse, economic/financial abuse and damage to property. For further information please read:
1. Adolescent-violence-to-parents-booklet
https://www.domesticabuseservices.org.uk/wp-content/uploads/2020/07/Adolescent-violence-to-parents-booklet.pdf
2. Information guide: adolescent to parent violence and abuse (APVA)
https://safelives.org.uk/sites/default/files/resources/HO%20Information%20APVA.pdf

Local supports for the family and perpetrator of the abuse

1. https://www.familylives.org.uk/advice/teenagers/behaviour/teen-violence-at-home/

2. Catch22 have launched the Beacon Family Hub in Hertfordshire:
The Hub provides support for families where a child or young person (under 18) is exhibiting abusive behaviour that is deemed controlling, threatening or intimidating to other family members. Referral can be made by emailing BeaconFamilyHub@catch-22.org.uk for a referral form.

11. Non-Fatal Strangulation and Non-Fatal Suffocation.

Non-fatal strangulation includes manual strangulation which is used to describe the application of pressure to the neck using the hands, chokehold or head lock where the external pressure is applied by an arm around the neck (known 'martial arts' grappling hold), ligature e.g., a scarf or belt tightened around the neck or hanging.
Non-fatal strangulation can be used as a form of coercive control and assault in domestic abuse and a history of strangulation can increase the risk of an eventual fatality. Cases reported in Hertfordshire include teenagers as well as adults. Visible marks are not always present; the absence of marks should not undermine an account of non-fatal strangulation. Non-fatal strangulation is often used to instil fear and exert power and control. Victims who experience non-fatal strangulation may believe at the time that they will die as a result. Non-fatal strangulation is thought to be the second most common cause of stroke in women under the age of 40. Loss of consciousness, even temporary, can cause brain injury, this includes long-term neurological damage such as memory loss and facial droop and can create an increased risk of miscarriage.

A&E or ENT assessment might be required in presence of a recent episode of NFS or symptoms For further information about the medical response to non-fatal strangulation please see The royal college of physicians guidance on Non-fatal strangulation in physical and sexual assault. (please note this was published before the Domestic Abuse Act became law)

Section 70 Domestic Abuse Act 2021 (DA Act 2021) introduced the offences of non-fatal strangulation and non-fatal suffocation of another person; clarifying by restating in statute the general position that a person may not consent to the infliction of serious harm and, by extension, is unable to consent to their own death. A person disclosing NFS should be encouraged to report it to the police, the IDVA service can support with this.

12. 'Honour' Based Violence, Forced Marriage and Female Genital Mutilation

There are several abuses that sit under the definition of domestic abuse, but which require a particular response.

‘Honour’ Based Violence
HBV is an umbrella term for a range of abuses perpetrated in the name of ‘honour’. Victims are perceived by the perpetrators to have done something which dishonours their family & the wider community.

Possible indicators of ‘honour’ dynamics may include:

- Disclosure of a planned marriage that the person is unhappy about
- Threats or pressure from family, extended family or others in the person’s community
- Anxiety that disclosures made will not be relayed back to family
- Patients always being accompanied by family members
- Disclosures related to HBV need to be responded to quickly and robustly. ‘Honour’ dynamics can escalate to ‘honour’ killings rapidly without indicators of worsening violence. You should take the following steps:
- stablish the wishes of the person at risk and explore what they think may happen.
- connect the person with a specialist domestic abuse service or national HBV charity such as Karma Nirvana (https://karmanirvana.org.uk/) immediately. If you are able, offer them a side room to speak with a support worker there and then.
- assure them of confidentiality and make sure patient files are properly protected.
- establish a code word for communicating by phone so as to prevent others trying to gain information by posing as your patient.

Forced marriage

Victims of forced marriage may be taken out the country and forcibly married. Young people, particularly women, may be taken overseas under the guise of a ‘holiday’. Resisting a marriage can
lead to abuse, violence, and ‘honour’ killings. Additional awareness of the signs of forced marriage for nurses offering travel vaccinations is beneficial.

If there are concerns that a patient may be at risk of a forced marriage, they should be spoken to on their own.

- record the concern including who they will be marrying, where, flight details if applicable.
- contact the Foreign and Commonwealth Office Forced Marriage Unit forced marriage. They give advice and assistance to people who fear they are going to be forced into a marriage abroad and those people who have been forced into a marriage and do not want to support their spouse’s visa application.0207 008 0151 (Mon–Fri, 9am–5pm) or 020 7008 1500 (emergency out of hours) fmu@fco.gov.uk

Female Genital Mutilation

Female Genital Mutilation (FGM) is a serious health threat to girls and women. It is the cut, removal or change of female genitalia for no medical reason. The prevalence rate in the UK is estimated to be
4.9 per 1000 population. Girls are at risk from around the ages of 4 to 14, with the school summer holidays being a particularly high-risk time.
Factors that may heighten risk of FGM include: History of FGM in family - Any girl who has a sister who has already undergone FGM must be considered to be at risk, as must other female children in the extended family. Any girl born to a woman who has been subjected to FGM may also be at risk.

GPs are in a strong position to identify victims of FGM and girls at risk. Health Education England have created a short e-learning module including examples of sensitively addressing the issue with patients. https://www.e-lfh.org.uk/programmes/female-genital-mutilation/

It is compulsory for regulated professionals to report directly to the police when anyone aged under 18 makes a first-hand disclosure of FGM or FGM is found on examination. For more information see the Hertfordshire Multi-agency FGM Pathways
The NSPCC operate a free FGM helpline https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/female-genital-mutilation-fgm/

Resources

- RCGP page on FGM which includes guidance on reporting. https://www.rcgp.org.uk/policy/rcgp- policy-areas/female-genital-mutilation.aspx
- Dept of Health FGM Safeguarding Guide https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525390/FGM_safeguarding_report_A.pdf
- NHS FGM guidance https://www.nhs.uk/conditions/female-genital-mutilation-fgm/
- NHS England FGM Pocket Guide https://www.england.nhs.uk/wp-content/uploads/2016/12/fgm-pocket-guide-v5-final.pdf
- Gov.UK Forced Marriage guidance https://www.gov.uk/guidance/forced-marriage

13. Inclusivity

It is recognised that some people experience additional barriers to reporting DASV and to seeking help because of structural inequalities. This Practice recognises the importance of adapting our approach to meet the needs of all our patients and staff.

Ethnic Minorities
Language and cultural barriers can make it more difficult for some people to disclose abuse. When conducting clinical enquiry

- Take time to explain what you are asking and why.
- Consider that some patients may feel more comfortable talking to a clinician of a particular gender and offer this option.
- Family members, partners or friends should never be used as translators when enquiring into DASV with a patient. An independent interpreter service should be used.
- Request a translator of the gender that the patient feels most comfortable with. If this is unclear, asking for someone of the same gender as the patient is reasonable.

Polish domestic abuse support https://www.vestasfs.org/domesticviolence Middle Eastern and Afghan domestic abuse support http://ikwro.org.uk/
Older people

Staff must apply the DASV policy to all patients and colleagues, irrespective of age and not assume that older or elderly people will not be experiencing domestic abuse or sexual violence.

Consider that the patient may be frightened of or feeling pressure from a range of family members.

The patient may believe that they have reduced options because of their age or that they have to ‘put up with’ abuse. It is important to assure patients that specialist organisations are experienced in supporting people of all ages and that no one has to endure abuse.

Resources for older people affected by domestic abuse
https://www.splitz.org/docs/TALK/Relationships_Later_in_Life.pdf

For more information on older people’s experiences of domestic abuse
https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

Lesbian, Gay, Bisexual and Trans+ people

LGBT+ people experiencing DASV are less likely to be identified or referred for support.

Staff must adopt gender neutral language when enquiring about domestic abuse and sexual violence; for example, using the term 'partner' rather than assuming the gender of the person who may be perpetrating abuse.

Local DASV services are positioned to offer support, but some patients identifying as LGBT+ may prefer to speak to an LGBT+ specific service.

GALOP – National LGBT+ domestic abuse helpline. https://galop.org.uk/ **020 7704 2040**
For more information on LGBT+ people's experiences of domestic abuse
https://safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse

People with disabilities and learning disabilities

It is often wrongly assumed that people with disabilities and learning disabilities will not have intimate relationships and that they are not at risk from sexual assault/abuse. Evidence shows that the risk of abuse can be higher for people with disabilities.

- Research shows that regular health checks for learning disabilities can often uncover treatable health conditions, and also reduces fear of going at other times; this allows patients to talk about anything that is worrying them.
- It is important to ask clear questions in language that the patient understands.

Resources for people with learning disabilities experiencing domestic abuse
https://www.choicesupport.org.uk/about-us/what-we-do/supported-loving/supported-loving-toolkit/domestic-violence-and-women-with-learning-disabilities

Accessible leaflet on domestic abuse for women with learning disabilities https://cdn-researchkent.pressidium.com/tizard/wp-content/uploads/sites/2302/2019/12/final-accessible-leaflet-1.pdf

For more information on disabled people's experiences of domestic abuse
https://safelives.org.uk/knowledge-hub/spotlights/spotlight-2-disabled-people-and-domestic-abuse

14. Support for employees

This part of the policy highlights additional steps to take as an employer with a duty of care to staff.

All the guidance in this policy applies to employees as well as to patients.

The practice does not tolerate any form of abuse against its staff and will act robustly and supportively to employees experiencing domestic abuse or sexual violence. It is committed to reducing the impact of domestic abuse on staff, understanding the risks and consequences in the workplace, fully supporting colleagues and taking action against perpetrators of domestic abuse.

Managers should provide a sympathetic and supportive response to staff who are victims of domestic abuse and take action to improve their safety at work.

- To take responsibility to enquire when concerned about an employee's personal home life.

- To give space, time and a degree of openness for individuals to feel able to talk at the time or at a later date and to create an environment in which employees feel able to come forward for support.

- To listen, reassure and support employees and respond in a sensitive and non- judgmental manner, referring them for appropriate support.

- To seek support and guidance from the DASV lead if consent is given.
- To consider the impact of domestic abuse on the staff members ability to recognize and respond to domestic abuse if disclosed by patients.

Employees affected by DASV can expect:

- A positive and sympathetic response.
- A meeting with the Practice DASV lead and/or Practice Manager to explore what the practice can do to support you.
- Time and space to make choices and to be supported, whatever decision you make. This can include paid leave.
- Practical support depending on what you need. For example, being escorted to your car after work if you're feeling at risk or a block on calls being put through to you if you're being harassed.

It is appreciated that you may choose not to share your situation with other colleagues. Disclosures will be handled with the upmost sensitivity and confidentiality whilst following any appropriate safeguarding steps that may apply.

Safety

To improve safety in the workplace, consider whether the practice can support with the following:

- Changing work hours or work base if stalking or harassment is a feature
- Restricting the abuser's access to the building or being able to contact the victim whilst at work.
- Allocating a car parking space that is well lit and near to the building
- Escorting the member of staff to and from their car or public transport.
- Providing storage for essential personal documents and items if there is concern these may be destroyed by the abuser
- A private room to meet with or call a domestic abuse or sexual violence advocate

Employees can self-refer to the local domestic abuse or sexual violence service (as appropriate). See the contacts section in appendix 3 for details of those services.

Staff perpetrating domestic abuse

When a member of staff has committed a criminal offence, patient and staff safety must be considered.

It is vital to respond in individual cases where concerns are raised about people working in a position of trust, ensuring that the risk is assessed, investigated where appropriate through internal

We suggest you specify appropriate people

We would suggest that this is exemplary policy. If you're able to include additional offers of support, these could be detailed in the policy.

The reference to IRIS can be removed for non-participating practices. You could insert details of the IRIS worker/ the local DASV services here for ease of access.

employment processes, and that risk management actions are identified and implemented as appropriate to the individual case.

- Ensure all adult or child safeguarding concerns that result from a concern about a position of trust are reported. Refer to the Local Authority LADO where the information indicates the person also works with and could pose a risk of harm to children. Follow the Local Authority Person in Position of Trust (PiPoT) guidance where the person also works with and could pose a risk of harm to vulnerable adults.

- Consider whether the allegation or concern indicates a criminal offence has occurred or may occur. If so, the allegation or concern must be reported to the Police. Early liaison with Police should take place to agree next steps and to avoid contamination of evidence. If a criminal investigation is required, this may take primacy over an agency or organisation's internal investigation.

- Where appropriate, notify and refer external agencies; to the CQC (where the person in a position of trust is working or volunteering in a CQC regulated organisation), statutory and other bodies responsible for professional regulation (such as the General Medical Council and the Nursing and Midwifery Council, The Charity Commission) and the DBS.

Staff who disclose that they are struggling with their own behaviour in a relationship can be encouraged to call the Respect helpline or access support through the Hertfordshire Change Project (see appendix 3).

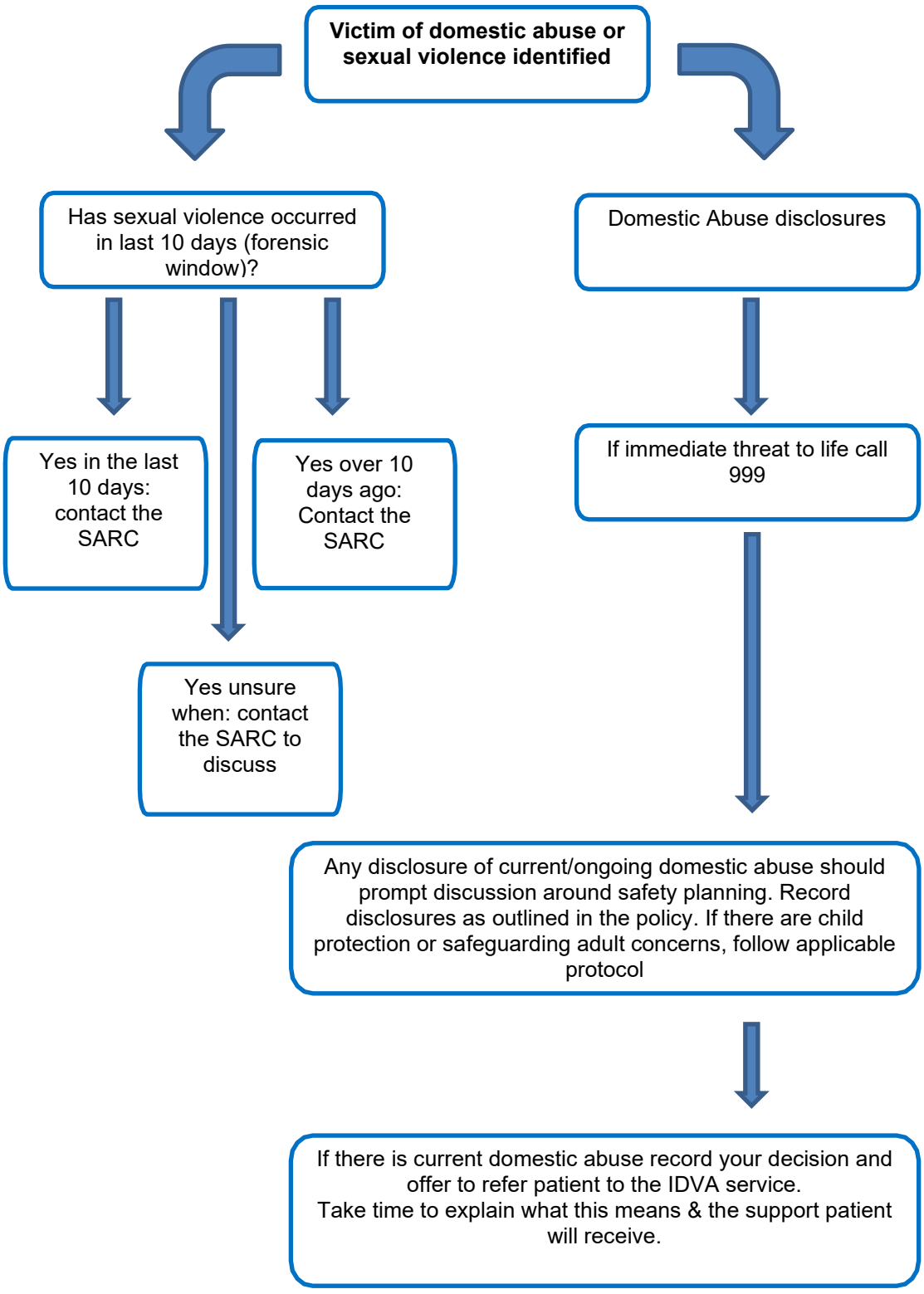
Appendix 1: The health markers of domestic abuse & sexual violence

Domestic abuse and sexual violence are the cause or precipitating factor of a range of mental and physical health complaints. A history of DASV can increase the risk of some conditions many fold. The following markers can help you identify patients who should be asked but is not an exhaustive list.

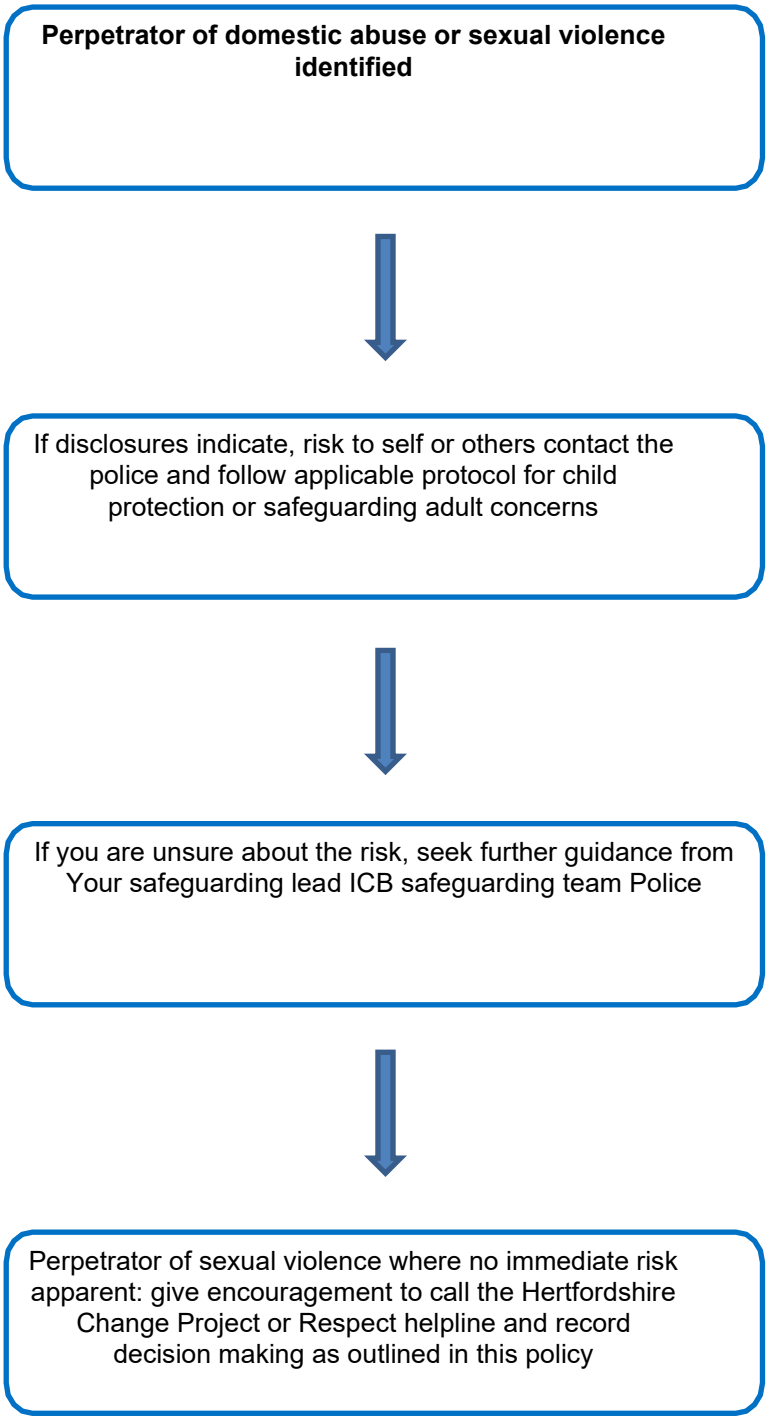
It is appropriate to exercise a low threshold for enquiry, asking a broad range of patients and asking often.

- Anxiety
- Broken bones
- Bruising
- Chronic pain
- Dementia can increase the risk of DA for the patient or their carer
- Depression
- Direct disclosure of assault
- Eating disorders
- Emotional distress; low self-esteem, general low mood.
- Fibromyalgia
- Gastrointestinal symptoms
- Gynaecological problems
- Insomnia
- Lower back pain
- Miscarriage
- Missed appointments
- Neurological symptoms
- PTSD
- Repeat attendance with partner present (must separate patient before enquiring)
- Repeat presentation to general practice
- Request for emergency contraception
- Self-harm
- Sexually transmitted infections
- Substance misuse
- Suicide ideation
- Unexplained injury

Appendix 2: Domestic Abuse & Sexual Violence Flowchart (adult victim pathway)
See Appendix 4 for contact details



Appendix 3: Domestic Abuse & Sexual Violence Flowchart (perpetrator pathway)



Appendix 4: Local & National Services

Contacts	
Hertfordshire IDVA Service	Tel: 0300 790 6772 Out of hours referrals will be responded to the next working day Out of Hours: 0800 328 7760 5pm-9am Mon-Fri, all day weekends Email: hertsidva@refuge.org.uk
Herts Domestic Abuse Helpline	Webpage: https://www.hertsdomesticabusehelpline.org/ Tel: 08 088 088 088 Email: Kim@mailpurple.org
Hertfordshire MARAC	Tel: 01707 638146 Email: hertsmarac@herts.pnn.police.uk
Hertfordshire Sexual Assault Referral Centre SARC	https://www.hertssarc.org/ 0808 178 4448 herts.sarc@nhs.net
Hertfordshire Change Project for Perpetrators	hertfordshire-change-limited-leaflet-v2.pdf (thechange-project.org
Hertfordshire Sunflower Information and Resources for people experiencing domestic abuse and professionals	https://www.hertssunflower.org/herts-sunflower.aspx
Freephone, 24-hour National Domestic Abuse Helpline	0808 2000 247 Webpage, including online chat: https://www.nationaldahelpline.org.uk/0808 2000 247
Men's Advice Line	Webpage, including online chat: https://mensadviceline.org.uk/ Tel:0808 801 0327 Email: info@mensadviceline.org.uk
Galop LGBT+ Domestic Abuse Helpline	Webpage: https://galop.org.uk/ 0800 999 5428

Appendix 5: Refuge - Hertfordshire IDVA Referral

Refuge
Hertfordshire IDVA Service

Telephone: 0300 790 6772	**Secure email:** herts.idva@refuge.cjsm.net		
DATE OF REFERRAL:			
NAME OF REFERRING AGENCY			
REFERRER'S NAME		**CONTACT NUMBER AND EMAIL**	
HAS THE CLIENT CONSENTED TO THIS REFERRAL? (please delete as appropriate)		**YES / NO**	

NAME OF CLIENT		**DOB**	
SAFE CONTACT NUMBER(S)		**ADDRESS:**	
ETHNICITY		**LANGUAGES SPOKEN INTERPRETER REQUIRED**	
IMMIGRATION STATUS		**DISABILITY OR HEALTH NEEDS**	
RELIGION (if any)		**SEXUAL ORIENTATION**	
MARITAL STATUS		**SUPPORT AGENCIES INVOLVED?** (please provide details, if known)	
Please provide reasons for this referral (including details of the most recent incident) and what kind of support is required –			

Children/ dependents names	**D.O.B *include pregnancy & edd**	**M/F**	**Where do the children currently live?**	**Relationship to perpetrator?**	**Is there current involvement with social services?** (please provide name of social worker if known)

Alleged Perpetrator Details Name & D.O.B.: Address: (if known) Relationship to referee:	(please state if perpetrator is spouse, ex partner, family member etc)

Refuge Hertfordshire IDVA service support high risk women and men experiencing abuse within intimate or family relationships.

Our IDVAs support:

- Women and men aged 16 and over, who are at risk of harm from a current partner, ex-partner or family members
- Survivors of domestic abuse, stalking, 'so-called' honour based abuse and forced marriage
- Survivors who live in Hertfordshire

The Hertfordshire IDVA service will provide free, confidential, non-judgmental, independent specialist support to high risk survivors. We can support survivors with their current needs which may include;

- CJS – support reporting to the police, explaining the process, pre – trial visits, attending court to give evidence, obtaining updates from court.
- Obtaining Civil orders
- Housing
- Safety planning and risk reductions
- Referral to other agencies
- Emotional Support

Appendix 6: Dash risk Checklist and guidance

Safe Lives Dash risk checklist -Quick start guidance

Appendix 7: Herts MARAC Referral Form Completion Instructions

HERTS MARAC Referral Form Completion Instructions - WITH REFERRAL FORM BELOW

Referring Agency: *Full name of the agency making the referral.*

Contact Name(s): *Full name of the person from the referring agency making the referral.*

Telephone / Email: *Contact details of referring agency and/or the person making the referral.*

Date: *Date the referral is being submitted.*

Victim Name: *Full name of the victim with the surname in capitals. Please include any aliases or different spellings. Agencies use this information to conduct their research in preparation for the meeting.*

Victim DOB: *Exact DOB. If not sure or there are different DOB's please also include these. Agencies will use the information to conduct their research.*

Address: *The victim's current address & postcode. This is important as it will determine which area the case will be heard in.*

Diversity Data: *B&ME – Black and Minority Ethnic. LGBT – Lesbian, Gay, Bi-sexual or Transgender. Gender – Male / Female. Disability/Impairment – as per the 'Definition of Disability under the Equality Act 2010'. There may be a number of reasons why people with disabilities/ impairments are not being identified at Marac. One explanation could be the issue of 'hidden impairments' i.e., a person's injury or condition that is not noticeable or visible which can include epilepsy, diabetes, cancer, heart, liver/kidney problems and mental health issues.*
This information is required in order for an Equality Impact Needs Assessment to be conducted annually in relation to MARAC to identify the needs of the local population including what additional services are required to meet our needs.

Telephone No: *Victim's contact number, ensure it is relevant and includes the best time to call the victim and is safe.*

Is this number safe to call? *This is very important – please ensure you tick yes or no. The referrals are forwarded to IDVA who will try to make contact, they will need to know whether it is safe to call the victim or not.*

Perpetrator(s) Name: *Full name of the perpetrator with the surname in capitals. Please include any aliases or different spellings. Agencies use this information to conduct their research in preparation for the meeting.*

Perpetrator(s) DOB: *Exact DOB. If not sure or there are different DOB's please also include these. Agencies will use the information to conduct their research.*

Perpetrator(s) Address: *The perpetrator's current address & postcode. If you are unsure what the address is please put 'Unknown' or if the perpetrator has no address please state 'NFA – No fixed abode'.*

Perpetrator's Relationship to Victim: *Please state whether they are Partner's, Ex-Partners, Mother, Father, Son, Daughter, Brother, Sister etc.*

Children & UBB's: *Please state the names of the children with their surname in capitals. Please include all names or different spellings. Agencies (in particular Children Services) will need this information to conduct their research. Unborn babies (UBB) to be included here.*

DOB: *Please ensure the children's DOB is included. The Case List will list the youngest child first. In the case of UBB, indicate number of weeks of pregnancy.*

Relationship to Victim: *Please state if the victim is mother or father to the child. If no relation to victim, then list as none.*

Relationship to Perpetrator: *Please state if the perpetrator is mother or father of the child. If no relation to perpetrator, then list as none.*

Who does the child live with (and where if not with the victim)?: *Permanent address for the child. If they are not living with the victim or perpetrator please ensure you state where the children are residing and who they are with i.e., grandmother.*

School: *If known.*

Reason for Referral / Additional Information – Typically only one criteria should be ticked. Allowances may be made where a MARAC Repeat is concerned.

Professional Judgement: *If a professional has serious concerns about a victim's situation, they should refer the case to MARAC. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers, particularly in cases of 'honour'-based violence. This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.* ***All agencies should note that if they are referring under "professional judgement" then they are saying that the victim is at "risk of serious harm or homicide". They must complete their rationale for referring under thiscriteria within the space provided on the MARAC Referral form.***

Rationale**:** *If you are referring under the criteria of professional judgement, please ensure you add your rationale for the referral in this box.*

Visible High Risk: ***DO NOT PUT A TICK IN THIS BOX, ONLY ENTER THE NUMBER OF 'TICKS' ON YOUR RISK ASSESSMENT)*** *If you have ticked 14 or more 'yes' boxes on the DASH risk identification checklist, the case would normally meet the MARAC referral criteria. However, as a general rule a case would not be deemed appropriate for a MARAC referral if the only risk factors were historic ones, and none related to abuse which had occurred within the last three months.* ***If referring under this criteria you MUST submit the DASH Risk Assessment with the referral.***

Potential Escalation: *the number of callouts to the victim as a result of domestic abuse in the past 12 months. This criterion can be used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC. In Hertfordshire, the case will be referred to MARAC if there have been 4 callouts in 12 months.*

MARAC Repeat: *a repeat case is one which has been previously heard at a MARAC and at some point in the 12 months from the date of the last referral, a further incident is identified between the same victim and perpetrator. Any agency may identify this further incident. A further incident need not be criminal, violent or threatening but should be viewed within the context of a pattern of coercive and controlling behaviour.*

Important – Provide date and summary details of latest incident that triggered this referral: *Please ensure you include the date of the incident,* the type of crime *i.e. Non Crime Domestic (NCD) or Assault, Harassment etc. and brief summary of the incident.* ***Dates are crucial and provide significant timeframes****. There is no need to include a crime number in the information as this is irrelevant to MARAC.*

Is the victim aware of MARAC referral? *Have you spoken to the victim and told them you are referring them to MARAC? If not, why not?*

Has consent been given? *Has the victim given their consent for you to refer them to MARAC?* **If NO, why not?** *Please state the reason why the victim is not aware of the referral or why the victim has not given consent.*

If the Victim has disclosed criminal offences do they consent to Herts Police contacting them? Please provide safe contact details to enable this. *This is self-explanatory and applies to all agencies other than Police. Please ensure this question is asked to all victims and provide a safe, current contact number/email address.*

Who is the victim afraid of? *To include all potential threats, and not just primary perpetrator, i.e. include perpetrator's family if applicable.*

Who does the victim believe it is safe to talk to? *Please include this detail if known*

Who does the victim believe it is not safe to talk to? *Please include this detail if known*

Has the victim been referred to MARAC previously? *If known please include the date the victim was last heard at MARAC*

Appendix 8: Herts MARAC Referral Form

PLEASE COMPLETE REFERRAL FORM BELOW AND EMAIL TO HERTS MARAC. DO NOT E-MAIL POLICE MARAC REFERRALS TO IDVA. THIS WILL BE DONE BY THE MARAC TEAM (POLICE CORE GROUP MEMBER) ONCE SATISFIED THAT THE MARAC REFERRAL CRITERIA HAS BEEN MET.

HERTS MARAC REFERRAL

SEND TO THE MARAC TEAM AT HertsMARAC@herts.pnn.police.uk
(all police referrals to be submitted via Athena)

Referring Agency:		**Date referral completed:**	
Agency Contact Name(s):		**Agency Tel No:** **Email:**	
Victim name:		**Victim DOB:**	
Victim address:		**Diversity Data:** **B&ME** **LGBT** **Disability/Impairment** (can include epilepsy, diabetes, cancer, heart, liver/ kidney problems, mental health)	***THIS BOX MUST BE COMPLETED*** **Select Y or N** **Select Y or N** **Select Y or N and nature of disability/impairment**
Victim Tel No:		**Gender** ***(delete as appropriate)***	MALE / FEMALE
Is this number safe to call?		**Any relevant contact info** (e.g. times to call)	

Perpetrator(s) Name:		**Perpetrator(s) DOB:**	
Perpetrator(s) Address:		**Relationship to Victim:**	

Children please add extra rows if necessary	**DOB** dd.mm.yy	**Relationship to Victim** son/daughter/none	**Relationship to Perpetrator** son/daughter/none	**Who does the child live with and where ?**	**School** if known

REASON FOR REFERRAL/ADDITIONAL INFORMATION

Visible High Risk (**DO NOT PUT A TICK IN THIS BOX** , put the number of ticks on the Safelives DASH risk assessment) Visible high risk means *14 ticks or more.* **Ensure DASH is sent with this referral.**	**No. of ticks on DASH RA**	**Potential escalation** (*4 or more incidents reported in the past 12 months*)	**Y / N**
Professional Judgement ***If referred under this criteria, provide a rationale in the box below as to why and what the serious concerns are.***	**Y / N**	**MARAC Repeat** (further incident identified within twelve months from the date of the last referral)	**Y /N**
Rationale:			

INCIDENT THAT LED TO THIS REFERRAL

Write a short summary of the LATEST INCIDENT that triggered this referral.	**DATE OF INCIDENT:** **INCIDENT DETAILS:** *

ADDITIONAL INFORMATION

Is the Victim aware of MARAC referral?	**Y/N** (*if no why not?)*
Has consent been given?*)*	**Y/N** (*if no, why not?)*
If the Victim has disclosed criminal offences do they consent to Herts Police contacting them? Please provide safe contact details to enable this.	
Who is the Victim afraid of? *(include all potential threats, not just primary perp)*	
Who does the Victim believe it is safe to talk to?	
Has the Victim been referred to MARAC previously?	**Y/N** (*If yes, provide actual date of MARAC (not when ref was dated or sent*)

Appendix 9: Information Sharing Consent Form

Victim name and DOB			
Victim address			
Children	**DOB**	**Address**	**School (if known)**

Who is at Risk? *(e.g. Children, client, family, others)*	**Who are they at risk from? *(e.g. partner, ex-partner, family, self)***	**What are the concerns around this risk?**	**What are the immediate risks to this victim?**	**Risk Identified through Risk Assessment**

Dash risk checklist (*if it has been possible to complete this, attach it here)*	
Details of incident / information causing concern *(include source of information)*	

Legal Authority to Share

Protocol relevant		If yes, *please detail*	

Legal grounds (If yes, please tick one or more grounds below)	*Y / N*
Prevention / detection or crime and/or apprehension or prosecution of offenders (DPA, sch 29)	
To protect vital interests of the data subject; serious harm or matter of life or death (DPS, sch 2 & 3)	
For the administration of justice (usually bringing perpetrators to justice (DPA, sch 2 & 3)	
For the exercise of functions conferred on any person by or under any enactment (police / Social Services) (DPA, sch 2 & 3)	
In accordance with a court order	
Overriding public interest (common law)	
Child protection – disclosure to social services or police for the exercise of functions under the children act, where the public interest in safeguarding the child's welfare overrides the need to keep the information confidential (DPA, sch 2 & 3)	
Right to life (Human Rights Act, art. 2 & 3)	
Right to be free from torture, of inhuman or degrading treatment (HUMAN RIGHTS ACT, ART. 2 & 3)	

Balancing Considerations (please tick)

Pressing need		**Risk of not disclosing**	
Respective risks to those affected		**Interest of other agency / person in receiving it**	
Public interest of disclosure		**Human rights**	
Duty of confidentiality		**Other**	
Comments			
Internal consultations *(Names / Dates / Advice / Decisions)*			
External consultations *(Home Office, Information Sharing Helpline)*			

Client Notification

Client notified		**Date notified**	
If not, why not?			

Review

Date for review of situation ***(review to include feedback from the agencies informed as to their response)***	
Name of person responsible for ensuring the situation is reviewed by this date	

Record

The following information-sharing in Case File:

- Date info shared
- Agency and named person informed
- Method of contact (by email, letter, phone call)
- Legal authority for each agency

Signature of caseworker	
Date (as signed by caseworker)	
Signature of manager	
Date (as signed by manager)	

Appendix 10: Acronyms

DA	Domestic Abuse
DASV	Domestic Abuse and Sexual Violence
DASH	Domestic Abuse, Stalking, Harassment and Honour Based Violence (risk checklist)
FGM	Female Genital Mutilation
LADO	Local Authority Designated Officer
MARAC	Multi-agency Risk Conference
MASH	Multi-agency Safeguarding Hub
PiPoT	People in a Position of Trust Protocol
RIC	Risk Indicator Checklist (also known as DASH)
SARC	Sexual Assault Referral Centre
SV	Sexual Violence

Appendix 11: Equality Analysis

Title of policy, service, proposal etc being assessed:
GP Domestic Abuse & Sexual Violence Policy Toolkit

What are the intended outcomes of this work? Include outline of objectives and function aims This policy toolkit has been designed to enable GP practices to implement their own comprehensive domestic abuse and sexual violence policy, covering both staff and patients affected by domestic abuse and/or sexual violence.
How will these outcomes be achieved? What is it that will actually be done? What is it that the proposal will stop, start or change? GP practices can adapt and adopt this policy for their staff to follow the policy direction in relation to domestic abuse and sexual violence that fall within the remit of this policy
Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc. If you believe that there is no likely impact on people explain how you've reached that decision and send the form to the equality and diversity manager for agreement and sign off All staff working in GP practices and the service users that are defined within the remit of this policy

Evidence
Impact Assessment Not Required There may be occasions the papers presented do not require a decision and/or will have no impact (positive or negative) on people from the equality and health inequality groups, for example papers presented for information or for assurance. Where you can show that this is the case use this box to explain why. You will not need to complete the rest of the template. The template will still need to be sent to Paul Curry who will, if it is the case, confirm that no equality impact assessment is required. As stated in section 2 of the policy, the equality needs of individuals when interacting with the policy and process will be met to ensure equity of outcome, therefore, providing those needs are met, the impact is expected to the neutral.
For your records **Name of person(s) who carried out these analyses:** Named Nurse for Adult Safeguarding HWEICB
Date analyses were completed: 25th October 2022

Equality and Diversity Lead Sign off
This policy toolkit recommends to GP practices an approach to implement to develop their own domestic abuse and sexual violence policy. At an ICB level it does not start, stop or change and ICB policy practice or procedure where a persons equality group status could impact on the implementation of the policy. At a practice level, practices should consider the equalities make up of their staff to ensure that the policies they put in place meet the needs of the relevant equality groups. Therefore, at an ICB level, a full equalities impact assessment is not required. Paul Curry, Equality and Diversity Lead, 25th October 2022.