RESPONDING TO DOMESTIC VIOLENCE AND ABUSE POLICY

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Consultation Process:	Consulted through Safeguarding Committees and Medicines Optimisation, Pathways and Protocols Committee

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Approval Given By:	Dr. M S Hassan and partners

Document History

Version	Date	Significant Changes
V1	July 14	
V2	July 15	nil

POLICY VALIDITY STATEMENT
This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.

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1. Introduction

For the purposes of this policy, Northumberland, North Tyneside, Newcastle North and East, Newcastle West, Gateshead, South Tyneside, Sunderland, North Durham, Durham Dales, Easington and Sedgefield, Darlington, Hartlepool and Stockton on Tees and South Tees Clinical Commissioning Groups will be referred to as "the CCGs".

Primary Healthcare Centre Chopwell is committed to improving the health and wellbeing of all patients and as such recognises that domestic violence/abuse adversely affects the health of individuals (primarily women and children), vulnerable adults, families and communities. Whilst the practice acknowledges that domestic violence/abuse knows no boundaries and occurs equally across all social strata it recognises this will have a huge additional negative impact on the health and well-being of victims. This policy should be read in conjunction with associated policies particularly the Safeguarding Children and Safeguarding Adults policies.

1.1 Status

This policy is a corporate policy.

1.2 Purpose and scope

This policy document explains the role of the practice in both identifying domestic violence/abuse and supporting service users who experience it. The policy confirms the practice's commitment to relevant guidance and identifies actions the practice will undertake to support staff and service users in identifying, preventing and supporting victims and their children.

2. Definitions

The following terms are used in this document:

The 2013 definition of domestic violence and abuse 2013 states:

"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sex. This can encompass but not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

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 means needed for independence, resistance and escape and regulating their everyday behaviour.

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

This 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.”
Home Office March 2013

A stalking law came into force under the Protection from Harassment Act (amended by the Protection of Freedoms Act 2012) in November 2012. This covers conduct that amounts to harassment or stalking, fear of violence, or stalking which causes distress, which has a substantial effect on the victims usual day to day activities, which the perpetrator knows or ought to know amounts to stalking or fear of violence, a course of conduct that occurs on at least two occasions. There are two new offences in relation to this Law. It is known that stalking can last months and years and many victims endure serious psychological harm over a prolonged period.

Research suggests 1 in 4 women and 1 in 6 men will experience domestic violence at some time in their lives, with women at greater risk of repeat victimisation and more serious injuries (Home Office 2004). Domestic abuse is known to start or escalate in one third of cases where a woman is pregnant.

Domestic violence / abuse is not specific to any strand of society and the British Crime survey 2000 highlighted that:
• Of all crimes highlighted 1 in 20 were classed as domestic violence
• Domestic violence accounts for almost a 25% of all violent crime
• The police receive an average of 13000 calls every day about domestic violence.

Domestic violence includes, but is not limited to:

• **Sexual Violence**
ANY non-consensual activity, including rape, sexual assault, coercive sexual activity or refusing safer sex.

• **Emotional/Psychological Abuse**
Intimidation, social isolation, verbal abuse, humiliation, constant criticism, enforced trivial routines.

• **Financial Abuse**
Stealing, depriving or taking control of money, running up debts, withholding benefits books and bank cards.
Perpetrators may use different forms of violence at different times. This policy and guidance applies equally to men who require advice or help whatever form it takes. Domestic violence is rarely a one off incident. More usually it is a pattern of abusive and controlling behaviour where the abuser exerts power over the victim. It occurs across society, regardless of age, gender, race, sexuality, wealth and geography.

3. The aim of the policy

The aim of the policy is to guide staff in the management of patients/service users who are/ or have experienced domestic violence/abuse. The practice will address the issue of domestic Violence /abuse and promote support for those who have experienced it.

4. Duties and Responsibilities

Council of Members	The council of members has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Accountable Officer	The accountable officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.
[Author]	The *author's title* will: List the responsibilities which the author has in relation to the policy.
[Titles of relevant officers]	The titles of any officers who have specific responsibility for implementation of any part of the process, clearly stating what that person's responsibility is, including who is responsible for drafting and updating any part of the document.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.

Roles and Responsibilities

Primary Healthcare Centre Chopwell is committed to protecting vulnerable adults and children. Where someone who is defined as a "vulnerable adult" is experiencing domestic violence then adult safeguarding procedures must be followed. Where the abuse of a child or children under 18 is identified or suspected, this must be defined as child abuse in line with the practice's Child Protection Policies and Procedures. Where the victim or perpetrator of

domestic violence is identified as having children or is pregnant, a referral to Children's Social Care will be made if the child or unborn is considered to be at potential risk. If a decision is made not to make a referral to Children's Social Care, information should be shared with other relevant professionals involved where appropriate e.g. health visitor, CPN. If there is some uncertainty regarding the level of risk, advice should be sought from the practice lead, Named GP or community health safeguarding team.

The practice lead for Safeguarding Children is Dr M S Hassan

The practice lead for Safeguarding Adults is Dr M S Hassan

The practice Safeguarding leads are responsible for ensuring the practice response to domestic violence and abuse. They will

- implement Primary Healthcare Centre Chopwell domestic violence and abuse policy
- ensure that the practice meets contractual guidance
- ensure safe recruitment procedures
- support reporting and complaints procedures
- advise practice members about any concerns that they have
- lead on analysis of relevant significant events
- determine training needs and ensuring they are met
- make recommendations for change or improvements in practice procedural policy
- act as a focus for external contacts
- have regular meetings with others in the Primary Healthcare Team to discuss particular concerns

In addition they will

ensure that practice members and any staff who are victims receive adequate support when dealing with domestic violence and abuse

- Respond appropriately if it becomes apparent a staff member is an alleged perpetrator

All members of the practice

- Have a responsibility to acknowledge domestic violence/abuse and take action to respond to their patients wishes and follow Domestic Abuse Flowchart (appendix)

- Should respect the wishes of patients who do not want to take further actions at the time of disclosure, must respect the need for patient's confidentiality but understand when it is necessary to disclose information

- Have an awareness of and understand the indicators which may lead to domestic violence/abuse and that this issue features highly in cases of child protection

- Know what process to follow if they are concerned a colleague is either a victim or perpetrator

- Attend training that raises awareness about Domestic Violence/Abuse and of the MARAC (Multi Agency Risk Assessment Conferences) process

- Must record positive disclosures of abuse.

- Must use appropriate codes to highlight domestic violence and abuse

  For victims:
  At risk of violence in the home 13VF (13VF)
  For perpetrators: History of domestic violence 14X3 (XaJhe)
  Or
  Alleged perpetrator of domestic violence 14XC
  Subject of MARAC 13Hm

Domestic Violence and Abuse Process

Primary Healthcare Centre Chopwell is committed to improving the health and wellbeing of all patients by:

- Promoting the message that domestic violence is unacceptable

- Domestic violence has a hugely negative impact in the health and well being of those that experience it. All staff working within the practice have a responsibility to respond appropriately to domestic violence victims and perpetrators

- Commitment to work in partnership with other agencies to support victims of domestic violence by using appropriate referral systems and to ensure perpetrators are held accountable

- Ensuring all staff have up to date and accessible local and national contact details

- The practice is committed to supporting the Multi-Agency Risk Assessment Conferences (MARAC) procedures by

- The collection and sharing of relevant health information

- Carrying out an assessment of risk within the practice or making a referral / encouraging engagement with an organisation such as Women's Aid or Victim Support who will undertake such assessments

- The identification and referral of patients at significant risk of serious or life threatening harm into the MARAC procedures, sometimes without express consent of the victim. Staff are advised if considering referral to MARAC to discuss the situation with one of the Safeguarding teams

- Re-referring to MARAC if the situation changes or they have new information

- Storing reports from MARAC in medical records and highlighting the records of victims and alleged perpetrators

Selective Enquiry

The practice will implement and promote the use of Selective Enquiry, identification and signposting to other support agencies.

Selective Enquiry forms the basis for providing victims who are experiencing abuse with information about the local specialised services available to them.

These specialist services include those provided by a variety of voluntary sector organisations, in particular by Women's Aid affiliated organisations and in some instances by Victim Support Independent Domestic Violence Advocates (IDVAs), Specialist Domestic Violence Units and Domestic Violence Officers within the Police Protecting Vulnerable Persons Unit.

These agencies will carry out a risk assessment. If a victim fails to engage with a specialist agency the practice will take steps to assess the level of risk using the CAADA-DASH checklist as a guide.

Selective Enquiry refers to asking direct questions in the presence of signs and indicators which may suggest abuse has taken place.

It is recognised that all staff within the practice should have an awareness of domestic abuse issues and be aware of reporting system. All health professionals should be able to carry out Selective Enquiries. The victim should be seen alone to ask about domestic abuse.

Assessment Technique/Process

- Staff must display a non-judgemental approach that is supportive to the abused person and use open questions

- Staff must be aware of their own prejudices/feelings/experiences and ensure that they do not act in a discriminatory way

- Questions should be asked in as quiet, private and safe environment as possible – ask to use the quiet room if required [i.e. Counsellor's room downstairs]

- The abused person should be seen on their own if possible. However, some

individuals will require another person present (preferably same gender) either as an interpreter for language differences, sign language interpreters or as an advocate, particularly for people with learning disabilities. Family members/friends must not be used in these roles.

- The abused person must understand the issue of confidentiality and staff should clarify for the person the limits of confidentiality with particular regard to Child Protection of Vulnerable Adult concerns.

- Staff with any concerns about how to respond to a disclosure should discuss the issues with the practice safeguarding lead for children or adults and take advice regarding the need to disclose information.

- All staff should document what has been disclosed in the medical records using appropriate Read codes.

- The victim will be given appropriate and timely information, advice leaflets about options e.g. signposting to support services including Women's Aid, IDVA or other agencies. Please note some victims may be placed at greater risk if the perpetrator finds any written information for example by searching handbags, purses and pockets, therefore it is important to ask the victim whether he / she wishes to have any written information.

- The issue of domestic violence/abuse should be reviewed in subsequent consultations to assess whether the situation has changed and to judge whether any further action is now needed.

- If there are any concerns regarding the mental capacity of the victim a Mental Capacity Act assessment must be performed to inform decision making.

Information Sharing

There are legitimate concerns about sharing information however GMC guidance on this is clear (*Confidentiality* (2009) para.36-39):

- *There is a clear public good in having a confidential medical service. The fact that people are encouraged to seek advice and treatment, including for communicable diseases, benefits society as a whole as well as the individual. Confidential medical care is recognised in law as being in the public interest. However, there can also be a public interest in disclosing information: to protect individuals or society from risks of serious harm, such as serious communicable diseases or serious crime; or to enable medical research, education or other secondary uses of information that will benefit society over time.*

- *Personal information may, therefore, be disclosed in the public interest, without patients' consent, and in exceptional cases where patients have withheld consent, if the benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential. You must weigh the harms that are likely to arise from non-*

disclosure of information against the possible harm, both to the patient and to the overall trust between doctors and patients, arising from the release of that information.

- *Before considering whether a disclosure of personal information would be justified in the public interest, you must be satisfied that identifiable information is necessary for the purpose, or that it is not reasonably practicable to anonymise or code it. In such cases, you should still seek the patient's consent unless it is not practicable to do so, for example, because*:

  (a) the patient is not competent to give consent, in which case you should consult the patient's welfare attorney, court-appointed deputy, guardian or the patient's relatives, friends or carers

  (b) you have reason to believe that seeking consent would put you or others at risk of serious harm

  (c) seeking consent would be likely to undermine the purpose of the disclosure, for example, by prejudicing the prevention or detection of serious crime, or

  (d) action must be taken quickly, for example, in the detection or control of outbreaks of some communicable diseases, and there is insufficient time to contact the patient.

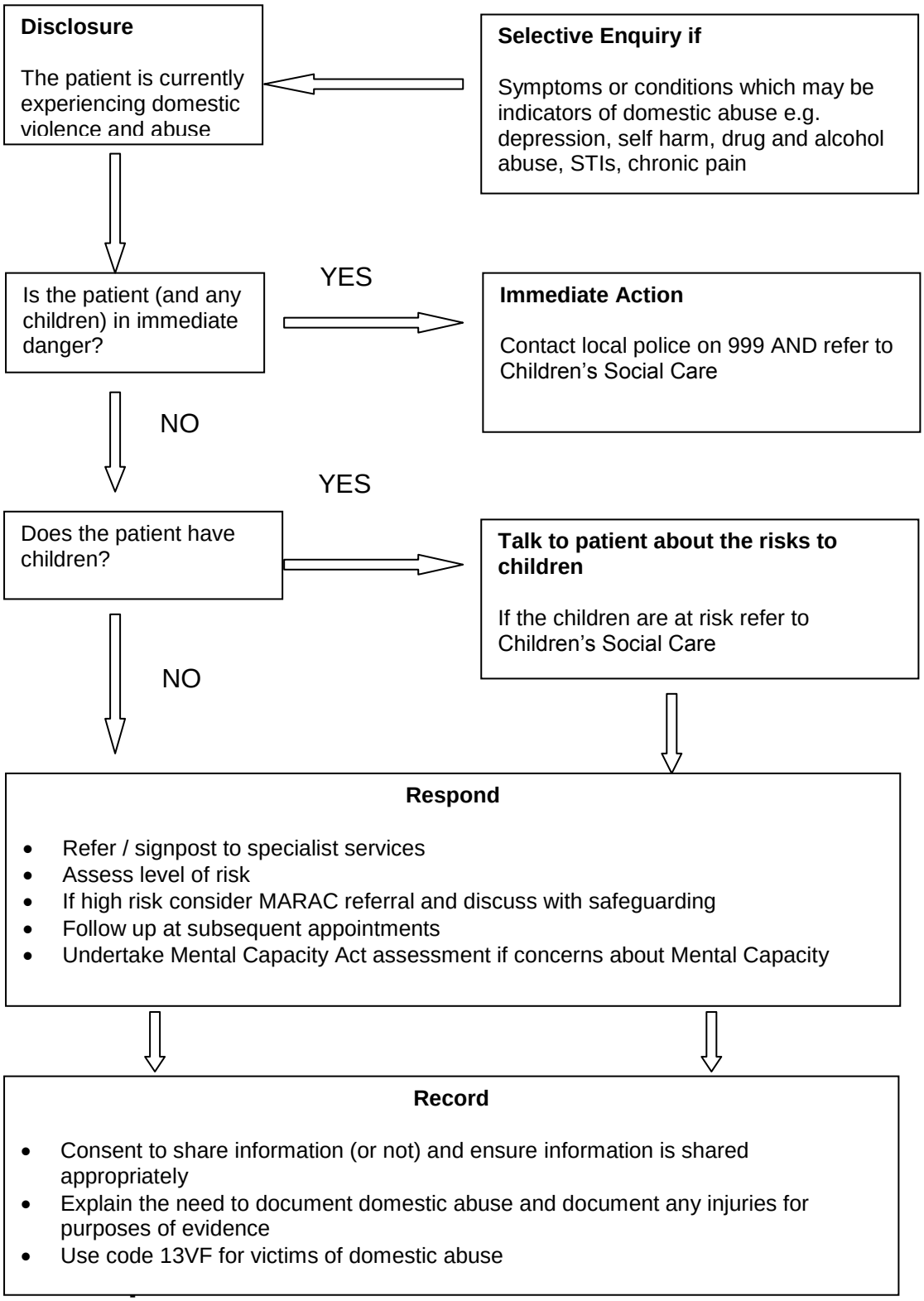
- *You should inform the patient that a disclosure will be made in the public interest, even if you have not sought consent, unless to do so is impracticable, would put you or others at risk of serious harm, or would prejudice the purpose of the disclosure. You must document in the patient's record your reasons for disclosing information without consent and any steps you have taken to seek the patient's consent, to inform them about the disclosure, or your reasons for not doing so.*

In terms of domestic violence key points are:

- The best interests of the child or unborn child are of paramount concern. This is reflected in judgements from the courts and in professional advice from the GMC. The duty to those with parental responsibility is a secondary consideration and should not divert the clinician from his/her prime concern for the child – clinicians should be reassured of the professional and legal framework that supports disclosures without consent even if concerns prove unfounded.
- Seek consent if it is appropriate to do so but consider the risks of seeking consent.
- Information may be shared without consent even when children are not involved if there is a risk to a vulnerable adult or when a serious crime has been committed or may be committed.
- The level of risk needs to be considered on a case by case basis with a consideration of the potential benefits and risks of sharing information.
- Only relevant information needs to be shared.

- Document in the records reasons for sharing or not sharing information.

Flowchart for Responding to Domestic Abuse



Adapted from CAADA/RCGP guidance on responding to Domestic Abuse
http://www.caada.org.uk/dvservices/resources-for-general-practice-managers.html

5. Implementation

5.1 This policy will be available to all Staff for use in relation to the specific function of the policy.

5.2 All directors and managers are responsible for ensuring that relevant staff within their own directorates and departments have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

It may be necessary to develop specific implementation plans.

6. Training Implications

The training required to comply with this policy are:

Primary Health Care Centre, Chopwell is committed to ensuring that all staff meet minimum requirements for Safeguarding Adults and Safeguarding Children training.

In addition clinical staff are encouraged to undertake specific training in domestic violence and abuse.

The practice will keep a record of all internal meetings, external training events attended by staff, audit undertaken and any changes implemented within the practice relevant to Domestic Abuse.

7. Documentation

7.1 Other related policy documents.

CCG CO15 Safeguarding Childrens Policy
CCG CO16 Safeguarding Vulnerable Adults Policy

7.2 Legislation and statutory requirements

Domestic Violence and Abuse: how health services, social care and the organisations they work with can respond effectively. NICE Guidance 50 – Feb 2014

7.3 Best practice recommendations

Resources for domestic abuse practitioners – Coordinated Action Against Domestic Abuse (CAADA)

8. Monitoring, Review and Archiving

8.1 Monitoring

The governing body will agree with the Adult Safeguarding Lead GP a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

8.2 Review

8.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. **No policy or procedure will remain operational for a period exceeding three years without a review taking place.**

8.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

8.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'document history' table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

9 Equality Analysis

10 Declaration

In law, the responsibility for ensuring that this policy is reviewed belongs to the partners of the practice.

We have reviewed and accepted this policy

Signed by: Dr M S Hassan

Signed: …….. Date: 5/3/2016
On behalf of the partnership

The practice team has been consulted on how we implement this policy in a practice meeting.

Signed by: Ms Samantha Cromar

Signed: …… Date: 5/3/2016

This policy will be reviewed in July 2016