

# IMPROVEMENT IN PRACTICE: THE IRIS CASE STUDY



February 2011

Implementing a  
successful primary  
care domestic  
violence service:  
early experiences



*Identify Innovate Demonstrate Encourage*

# ‘THE SUCCESS OF A SOUND QUALITY IMPROVEMENT INTERVENTION, FAITHFULLY IMPLEMENTED AND LOCALLY LED ... IT SPEAKS TO THE POWER OF THE RIGHT CLINICIAN-PATIENT INTERACTION’

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## *About the Author*

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Following five years in hospital medicine, Kamran moved into medical journalism and has been deputy editor and acting editor of the *BMJ* (British Medical Journal) and editor of the World Health Organisation’s *Bulletin*, an international public health journal.

Kamran has played a leading role in online learning and knowledge sharing for health professionals. He created BMJ Learning, a website providing formal online learning for doctors and has been medical director of Dr Foster Ltd and Chief Executive of OnMedica Ltd, a specialist company in online learning technologies in this field. He is also an honorary senior lecturer at Imperial College and a Patron of the South Asian Health Foundation.

Currently, Kamran is editor of *Journal of the Royal Society of Medicine* and editor of the new online journal, *JRSM Short Reports*. He also writes for [cricinfo.com](http://cricinfo.com), a highly rated cricket website, and is author of the popular cricket blog *Pak Spin*.



## *Definition of domestic violence*

Domestic violence is defined here as threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are in the same family, or who are or have been intimate partners.

It is considered a severe breach of human rights with profound health consequences – particularly for women, who experience a greater proportion of domestic violence than men.

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*Improving quality is challenging, particularly in realising tangible gains. When the IRIS project, a team of practitioners and researchers supported by our Engaging with Quality in Primary Care programme, reported significant and measurable improvements in the quality of care provided to women experiencing domestic violence, we wanted to capture the story of what they did and the impact their work has been having.*

# Commentary

NHS services have a notably poor record when it comes to the identification and handling of cases of domestic violence. Women, who represent the majority of cases, may present with physical and mental health problems attributable to violence, often over a sustained period, without ever being asked the cause.

Improving the quality of care for the victims of domestic violence requires far more than ensuring they get effective and timely clinical treatment. In this regard, the IRIS project is pioneering, enabling primary care professionals to not only treat the immediate health needs of the woman in front of them but also to refer them to recognised experts, on the basis that this can have a lasting and transformative effect on that person's life.

The IRIS story captures the success of a sound quality improvement intervention, faithfully implemented and locally led. More subtly, it speaks to the power of the right clinician-patient interaction, not just the right clinical treatment. The IRIS approach trains and educates healthcare professionals to do more than simply treat the illness which they are presented with.

It has provoked careful but effective changes to the relationship between the patient and the healthcare professional.

Learning from IRIS and other Engaging with Quality schemes has informed how the Health Foundation views professionalism within the modern health service. IRIS demonstrates how a user-oriented approach and partnership working can produce notably successful results. These are just some of the key dimensions of a new model of what it means to be a health professional, which we will continue to explore.

As professionals in primary care and commissioning bodies enter a period of uncertainty (in England at least), the IRIS team face particular challenges in spreading the implementation of their approach. It could seem an inauspicious time to be trying to convince commissioners of this additional investment, even one based on relatively strong evidence, but in time we hope that GP commissioners will be looking for relatively straightforward and cost-effective approaches that transform the quality of patient care, particularly for the most vulnerable amongst their population.

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## SUMMARY

### CHALLENGE

Domestic violence is a major public health issue, and a risk factor for chronic ill health and premature death in women. It is under-recognised and undertreated in primary care. In a primary care training and support programme called Identification and Referral to Improve Safety (IRIS), doctors and nurses in the intervention practices were more likely to discuss referral to specialist domestic violence agencies with their patients than clinicians in the control practices, and more likely to refer those patients to the agencies. IRIS is now in its implementation phase, with a target of 12 primary care trusts (PCTs) for initial roll-out of the service.

### STRATEGIES

The programme aims to provide training and support for staff to bridge the gap between the voluntary sector and primary care, to harness the strengths of each, and to provide an improved domestic violence service. Local champions are essential to catalyse the approval and implementation of the service.

### AGENTS OF CHANGE

The programme involves advocate-educators, commissioning champions, clinical champions, training materials, and a referral pathway.

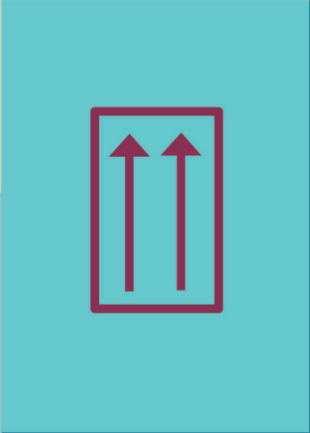
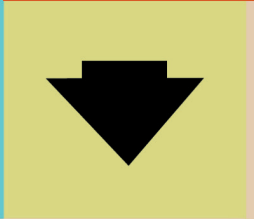
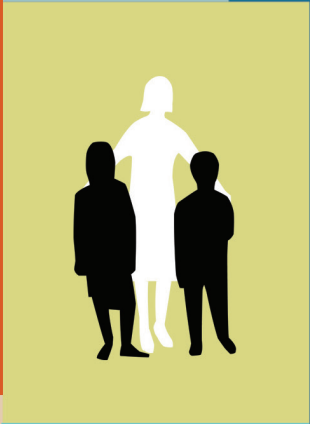
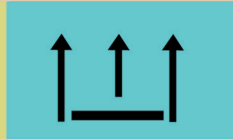
### PROGRESS TO DATE

There has been rapid acceptance of the IRIS implementation plan in Bristol. In Hackney, east London, an initial lack of a local champion and funding has meant that implementation has been slower. Ten other regions are showing interest in adopting the IRIS programme.

### LESSONS

The key lessons learned are as follows:

- Identify a commissioning champion who is ideologically committed to the service.
- Remember that clinical champions – both region-wide and within individual practices – will bestow legitimacy in the eyes of clinical colleagues.
- Make a strong economic case about cost savings: cost per quality of life year (QALY) is insufficient.
- Form links between sectors, to avoid the frustrations experienced by domestic violence agencies in trying to access primary care and improve services.
- As IRIS comprises a training and referral system, people will inevitably suggest amendments. Do consider the views of other professionals as the intervention is mainstreamed. However, there are core components that can be altered but not omitted.
- Make sure all groups have, and provide, a shared understanding of expectations. Good communications are essential.
- Create a feedback loop to keep GPs informed and engaged.
- Partner with a credible voluntary organisation that has good literature, provides a timely response, and employs advocate-educators with diplomatic skills.
- Involve service users in advisory and support roles to improve the delivery of the implementation and help other service users.
- Deliver on the promises you make about the service you are offering.



This case study seeks to explain the challenges faced by the IRIS team in attempting to implement a domestic violence service in the UK. It draws on a series of interviews with people involved with IRIS, along with IRIS study and implementation-phase documents and presentations made by the IRIS team. The interviews were conducted between July and November 2010.

## *The IRIS studies*



### *1 Randomised controlled trial*

The Identification and Referral to Improve Safety (IRIS) trial is a cluster randomised controlled trial of a primary care training and support programme to improve management of women experiencing domestic violence.

The researchers were awarded Health Foundation funding in 2007 and the trial began in the same year. The first training sessions were held in Hackney in September 2007 and in Bristol in the following month. These were the two locations for the trial. The trial finished in October 2009, and funding for implementation was agreed by Bristol PCT that autumn.

In May 2010 the Health Foundation agreed to provide further funding for the implementation phase.

In the trial, 24 practices received the IRIS programme and a further 24 practices were controls and did not receive the intervention. The primary outcome measure was the recorded referral of patients to advocacy services based in specialist domestic violence agencies. Secondary outcome measures included disclosure of domestic violence recorded in patient records.

Doctors and nurses in the intervention practices were more likely to discuss referral to specialist domestic violence agencies with their patients than clinicians in the control practices, and more likely to refer those patients to the agencies.

### *2 Qualitative study*

The qualitative study was nested in the randomised controlled trial, with 17 clinicians, 11 GPs and 6 nurses who had been involved with the trial being surveyed.

Levels of enquiry about domestic violence were influenced by perceived differences between the clinical roles of doctors and nurses, such as time constraints, level of patient interaction, awareness of patients' social history, scope of clinical interview, and patients' perceived notions.

Barriers to enquiry included lack of time, experience, awareness of effective community resources and interventions. Longstanding clinician-patient relationships could be a barrier or a facilitator to domestic violence disclosure.

### *3 Economic analysis*

This part of the programme is currently under way.

In 2011 the IRIS team will be publishing full data from the trial.

*When you ask Gene Feder about the progress of the IRIS project he immediately urges caution, saying that a successful research study does not necessarily lead to successful implementation. Feder is professor of primary care at Bristol University, a GP and the lead on IRIS. His research instincts keep his feet on the ground when proclaiming the success of any initiative – even one about which he is clearly passionate. The data, however, tell a story that would entitle him to be less modest.*

# A major public health problem

**D**omestic violence (also known as intimate partner violence) is a major public health problem. A burden of disease study in the Australian state of Victoria established that domestic violence is responsible for more ill-health and premature death among women under the age of 45 than other risk factors such as high blood pressure, obesity and smoking. Its effects extend beyond the many physical, psychological, and chronic health problems that affect an individual, harming children and communities too.

Population estimates for UK domestic violence prevalence range from 15% to 71%. Between 6% and 23% of women attending general practice will have experienced physical or sexual abuse from their partner or a previous partner in the preceding year. During a lifetime, the prevalence ranges from 21% to 55%. The variations reflect different prevalence in different countries, regions, and localities, as well as use of different measures of abuse.

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*‘Between 6 and 23% of women attending general practice will have experienced physical or sexual abuse from their partner’*

Domestic violence is a common problem that is almost invisible in primary healthcare, even though women would most like to receive support from their doctors. Only around 15% of women with a history of domestic violence have any reference to violence in their medical record in primary care. When a woman does disclose domestic violence, the response is frequently unsatisfactory as doctors and nurses are often unaware of appropriate interventions. ■

*‘We have some of the tools to make a difference,’ wrote Gro Harlem Bruntland, director general of the World Health Organization, when the World report on violence and health was published in 2002: ‘the same tools that have successfully been used to tackle other health problems. Violence is often predictable and preventable.’*

# Commissioners want cost savings

IRIS is one such tool that can make a difference. A cluster randomised trial run by Feder and colleagues has shown that a training and support programme based on IRIS and aimed at clinicians and administrative staff in general practices can achieve a significant increase in referrals to domestic violence support services. Doctors and nurses in intervention practices are substantially more likely than clinicians in control practices to discuss referrals to specialist domestic violence agencies with patients experiencing abuse.

These are impressive figures. A cost-effectiveness analysis of the IRIS pilot study, entitled Prevention of Domestic Violence (PreDoVe) and involving four general practices, has shown a cost-effectiveness ratio lower than the NHS Quality Adjusted Life Year (QALY) threshold.

But Feder does not believe that an argument based on cost per QALY is sufficiently strong to persuade commissioners. ‘They want to see cost savings,’ he explains, ‘and they need to know exactly what they can save. The NHS is under financial pressure, and these pressures will exist for at least the next five years.’ ■

## *The IRIS programme*



The Identification and Referral to Improve Safety (IRIS) programme comprises the following elements:

- two practice-based training sessions for clinicians and one shorter information session for the reception and administration team
- a prompt within the electronic medical record to ask about abuse
- a referral pathway to a named domestic violence advocate-educator (the individual who delivered the training)
- advocacy and signposting, provided for patients who are referred.

The purpose of the IRIS programme is to encourage clinicians and administrative staff to enquire about domestic violence and then either react with an appropriate response to disclosure or continue with usual care.

The implementation phase has two specific objectives:

- commissioning the IRIS model by PCTs (or their successors)
- developing and delivering an accredited national training and support programme for advocate-educators.



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## CONTRASTING EXPERIENCES

*While the trial data are helpful for Feder and colleagues to achieve their dream of implementing IRIS across primary care in the UK, the economic crisis has forced them to sharpen their focus and strategy. Top of their list has been to find a local champion to support the commissioning of IRIS. The experience of the first two roll-out sites has reinforced that priority.*

# Bristol & Hackney

**I**n Bristol, Jackie Beavington, assistant director of public health, has been a powerful advocate for the service. She understood the potential of IRIS from the outset in 2007, joined the trial steering group, and saw the interim results. Her support, and the strength of the data, created a favourable policy environment and allowed the IRIS implementation phase to begin in Bristol, almost as the trial finished in 2009.

Meanwhile, the scenario in the Hackney IRIS trial site was more complex. Changes in staff meant that there was no consistent representation on the project from the commissioners, and momentum was lost.

‘We hit the ground running in Hackney with the research phase of IRIS,’ explains Annie Howell, who was the advocate-educator in Hackney during the IRIS trial and is now the IRIS development lead there. ‘But the delay in the implementation phase of IRIS in Hackney was because the PCT had not agreed to fund the project. It has now. Bristol quickly agreed to the IRIS implementation phase because it is at the forefront of tackling domestic abuse, and IRIS has always had senior-level support.’

‘Although Bristol committed straight away,’ recounts Feder, ‘Hackney was resistant because the trust could see the financial crisis coming. GPs supported our campaign by writing to the deputy director of public health and the director of commissioning – who finally pushed it through – although committing the PCT to fund the programme only until March 2011.’

A pre-requisite for commissioning of the programme, according to Feder, is the support of a senior manager in the PCT: ‘You have to identify someone who is ideologically committed to the issue among the commissioners. People find it easy to leave it to somebody else, and nothing gets done. It is too much to hope for a passionate person in every PCT, and the abolition of PCTs means that we have to target GP consortia – although they will essentially employ some of the same people as the PCTs.’

‘We are in a privileged position in the struggle to get a new service commissioned by the GP consortia, because we are rooted in primary care and the IRIS model is focused on GPs – although the issue has been historically marginalised in healthcare. My hope is that we will be able to convince 12 PCTs, or their equivalent, to agree to implement IRIS by mid-2012.’ ■

## LOCAL CHAMPIONS

*Last year, in a major report, an NHS taskforce on the health aspects of violence against women and children urged PCTs and NHS trusts to work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse. It advised commissioners to ensure that appropriately funded and staffed services are in place, and that local 'violence against women and children' leads should be appointed.*

# The value of champions


**A** champion for the project among commissioners is just one element of the success of the IRIS project. Equally important is a local clinician champion to engage and help bestow legitimacy in the eyes of medical and nursing colleagues in primary care – especially in the first training session of an IRIS programme.

‘Moving from the trial to service in Hackney may be made more difficult not only because funding came through late, but because we need to identify a new clinical champion who will help train up the practices,’ says Medina Johnson, the Bristol advocate-educator, who is based in a specialist domestic violence support service. ‘We have Gene Feder in Bristol, and having a clinical champion helps you get through the door of a surgery.’ ▶



# ‘THERE ARE SOME POCKETS OF GOOD PRACTICE BUT NO JOINED UP THINKING’

ROXANE-AGNEW DAVIES, CLINICAL PSYCHOLOGIST, IRIS RESEARCH TEAM




‘There are some pockets of good practice but no joined-up thinking,’ agrees Roxane Agnew-Davies, clinical psychologist on the IRIS research team, domestic violence trainer, and developer of the original IRIS model with Gene Feder. ‘Health professionals stay out of initiatives. They are renowned for their absences. Advocates have problems getting into primary care services. We had to make links with partners in the domestic violence sector, but we also had to bridge the divide between the domestic violence sector and primary care.’

‘Gene Feder’s involvement was a great advantage in engaging people and winning hearts. People were willing to listen to a person they respected, and Gene’s role was an essential ingredient – especially when the project was moving slowly in Hackney.’ ■

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*‘Equally important is a local clinician champion to engage and help bestow legitimacy in the eyes of medical and nursing colleagues in primary care’*



### Role of practice champion

- acting as first point of contact for advocate-educators
- providing additional training about domestic violence
- offering support to clinical colleagues with dilemmas
- discussing disclosure and referral data
- feeding back on any problems with IRIS

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## THE VOLUNTARY SECTOR & PRIMARY CARE

*Carol Metters, director of Next Link Domestic Abuse Services, which helps more than 1,000 families a year, has grappled with how to link into primary care for almost 30 years. The belief that the voluntary sector is not credible, because it does not use the traditional medical model, is an important prejudice that the voluntary sector has to overcome, she believes. This is a source of frustration for domestic violence agencies that are struggling to persuade primary care staff to afford the issue the attention it deserves.*

# Integrating the voluntary sector

**F**inding a respected clinician champion was instrumental in breaking down those barriers. In turn, Metters and her agency joined Feder in applying for funding from the Health Foundation for the IRIS study, which has now led to the implementation phase of IRIS. For a cross-cutting intervention to succeed it is equally important for clinicians and researchers to partner with a credible voluntary organisation.

Metters and Next Link embraced the intricacies of applying for a grant to fund a randomised controlled trial. They had to learn the language and rituals of research. On their part, the researchers had to grapple with the nuances of service provision. Yet both parties were united in their enthusiasm for the IRIS project and a belief that they could make it work. Next Link brought the added benefit of being politically well connected – a priceless ability to access the right people immediately.

‘When we founded Next Link, our work was focused on the mental health service,

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*‘both parties were united in their enthusiasm for the IRIS project and a belief that they could make it work’*

rape and assault’, remembers Metters, whose contribution to the voluntary sector earned her an MBE in 2010. ‘We delved into the lives of women and discovered that domestic violence was a recurring theme – almost the background wallpaper to issues we were dealing with.

‘Initially, it was hard to get funding to work in the area of domestic violence, and we had to work under the umbrella of mental health. Then, about 11 years ago, we won a small amount of funding from Bristol City Council, which helped us employ four workers in domestic violence. We now employ 40 people in domestic violence services, with an annual turnover of £1.5m.’ ■

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## BROACHING THE SUBJECT

*But the challenge in primary care is not simply about the voluntary sector finding a way to be taken seriously by clinicians. The most common complaint from women who have been victims of domestic violence is that GPs are reluctant to broach the subject.*

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*‘They hope that somebody will ask them about it. They think that somebody will help – but nobody does’*

# ‘You blame yourself’

**W**omen go to their GP and are never asked about domestic violence,’ says Metters. ‘They hope that somebody will ask them about it. They think that somebody will help – but nobody does.’

Kim Sales has herself experienced domestic violence and is the service-user advisor on the IRIS steering group: ‘I thought the problem was with me: I thought I had a mental health problem. I didn’t have any help from my GP when I was going through domestic violence. Nobody would ask.

‘I attend appointments with women now, and I think it’s outrageous the way doctors talk to them. I just have to bite my tongue. I’m so sorry for the way they talk to women. I’m not surprised the women don’t go back to their doctor. I wish we had IRIS everywhere.

‘Abuse started during my first pregnancy and continued for 14 years. I was constantly depressed and crying. I was sent to see a psychiatrist. You blame yourself. You get into trouble and debt. This is how women feel, and what they experience.’

The IRIS project was the missing piece of the jigsaw in primary care, helping connect a passionate voluntary sector with health professionals. Several of the women who were helped by the IRIS programme, including Sales, subsequently took on roles as advisors, collaborators, and researchers within the trial.

‘My involvement with women has helped open up the conversations,’ explains Sales. ‘You need somebody to understand it otherwise you might not talk about it. If I can help somebody not go through what I went through, then it’s worth it.’

The success of the IRIS clinical trial meant that a cut-down version of the training intervention was offered to the 24 control practices when the trial finished. Surprisingly, only 16 practices took up the offer, although referral data suggest that such a minimal intervention does not increase referrals to specialist agencies.

‘The others have declined for various reasons,’ explains Johnson. ‘Practice managers will say, “Our GPs know about ►

## BROACHING THE SUBJECT

this. They are very experienced. No thank you,” or “Our GPs are too busy with swine flu,” or “We don’t have time for a two-hour training session, but you could tell us over a sandwich.”

Other clinicians support the improvement initiative but did not enjoy the period of change. Apart from supporting clinicians to manage change better, the IRIS team’s experience of the trial is that it could have done more to challenge the medical model of care in relation to the patient. More information could have been provided to help primary care staff understand the physical and psychological aspects of domestic violence. Certainly, a practice champion is important – and a carefully chosen one doubly so.

Kate Done, a GP in Bristol who was trained under the IRIS programme, believes that she is now more likely to recognise domestic violence. Her practice is an enthusiastic adopter of IRIS, and has incorporated asking about domestic violence into the day-to-day practice of clinical staff.

‘We became involved in the IRIS intervention study about two years ago,’ says Done. ‘Domestic violence is an issue in our area. IRIS is a well-presented, simple approach, and although it is one of many new services that we are offered, it is one that stood out as useful because it works.’

‘I probably didn’t really ask about domestic violence before IRIS, but I do ask regularly now, and I’m pleased that patients are willing to take our domestic violence leaflets and other information, and accept help.’ ■

**‘PATIENTS ARE WILLING TO TAKE OUR DOMESTIC VIOLENCE LEAFLETS AND OTHER INFORMATION, AND ACCEPT HELP’**

**KATE DONE, GENERAL PRACTITIONER , BRISTOL**

### *Role of advocate- educator*



- providing central training and support
- liaising with practice champion
- feeding back data on disclosure and referral
- acting as a source of domestic violence materials
- providing ongoing support of practice
- acting as first point of contact for referral
- providing advocacy and signposting

*The IRIS intervention involves two two-hour training sessions for clinicians, and a one-hour training session for the reception and administration team, in identifying domestic violence and understanding how to refer patients to an appropriate domestic violence service. Advocate-educators such as Medina Johnson and Annie Howell provide ongoing support to practices, and act in an advisory role to the practice team.*

# Advocate-educators must be diplomats

**T**he advocate-educators work in partnership to monitor referrals, make sure service users receive appropriate support, and feed back practice and patient progress. GPs like to know how many women have been helped in their practice. Ongoing contact is instrumental in raising awareness, reminding clinicians the service is not a one-off intervention, and overcoming barriers to service delivery.

‘One of the issues we need to address is the capacity of a whole-time equivalent advocate-educator,’ ponders Feder. ‘Our current best estimate is that 20–25 practices can be supported. Hackney wanted us to cover the whole PCT with one advocate, but we managed to persuade them this was not sensible.’

The IRIS team believes it is important to stick to its approach and formula, and argues its corner when people suggest amendments. It is important that the service remains standardised in the face of time constraints imposed upon primary care staff – both for the sake of the integrity of the clinical trial, and also the effectiveness of the intervention.

Standardisation helps maintain fidelity to the approach, although as the intervention is mainstreamed it is important to consider the views of other professionals. Core components that can be altered but not omitted.

Crucially, advocate-educators require refined diplomatic skills and a sixth sense for the fault lines between the voluntary sector and primary care services. The list of challenges is long. It begins with GPs saying they do not believe evidence of the clinical burden of domestic violence, and the whole clinical team regretting that if they accept the case put forward by domestic violence agencies, they are acknowledging that they have failed to identify these women for many years.

‘Women are let down by health professionals. People think domestic violence is rare and affects stereotypical people, and that it is not the role of the healthcare professional to intervene,’ explains Agnew Davies. ‘Advocate-educators need to be respectful of the other cultures involved, and help people develop the skills to ensure that asking about domestic violence becomes routine as taking a temperature.’ ■

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## FUTURE SUCCESS OF IRIS

*The success of IRIS hinges on uniting disparate tribes behind a common cause, and turning weighty evidence-based material into convenient literature, checklists, and algorithms. The intervention is not a whistle-stop conversation but an ongoing relationship of training and support, with a clear and workable referral pathway and a feedback loop. Ultimately, it is a simple service to address a complex medical and social problem.*

# A simple service for a complex problem





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## FUTURE SUCCESS OF IRIS

**W**e also need to be respectful of the relationships within clinical teams,' continues Agnew-Davies. 'We started with a poor response from nurses, because nurses didn't feel able to refer people directly. Also, there is a problem if nurses work in a hierarchical and gender-bound environment, because a joint educational session can be counter-productive. The answer is separate training sessions – for GPs, nurses, receptionists and admin staff.'

Confidentiality is another delicate area, albeit one that has a common set of principles in the voluntary sector and primary care. Domestic violence services have a reputation for being almost paranoid about giving out details of their users. Refuges do not release information about missing persons – even to the police.

Fundamentally, all stakeholders need to understand that not everybody operates in the same way. Each group, whether a domestic violence agency or a general practice, has its own challenges to overcome. Domestic violence agencies struggle to engage health professionals; health professionals struggle to identify patients; and patients struggle to receive the support they need. Each player is culturally bound, though striving for a common outcome. Now that IRIS has reached its implementation phase, the team can take forward the evidence from the IRIS trial, along with findings of the qualitative study.

'Before I joined IRIS, I had contact with one GP in three years,' recalls Johnson of her previous experience of working in domestic violence. 'That's why we are encouraged at this stage. The implementation of the service has commenced in Bristol and Hackney, and we are in discussion with people in around 10 other areas of the country. They all

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*'The implementation of the service has commenced in Bristol and Hackney, and we are in discussion with people in 10 other areas of the country'*

came to us: we did not have to bang the drum.

'We work in partnership, and people are interested enough to approach us, which saves us some groundwork. Interestingly, we have been approached by a mixture of people, including domestic violence co-ordinators, nurses, commissioners, colleagues based in public health and enthusiastic GPs.'

The IRIS team is preparing commissioning and training packages as part of the movement from a successful trial to a mainstream programme. Stage two of the programme – implementing the model – is being funded by the Health Foundation to ensure that the team is ready for any surge in enquiries once the research papers have been published. The team believes that cost savings should be demonstrable at the point of the initial conversations with commissioners. However, this is often difficult because of the conflict between the urgency of a policy initiative and the need for a slower research pathway. But the IRIS team has convincing data at its fingertips. ■

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## COMMUNICATION IS VITAL

*Those winning arguments and compelling data are meaningless if they are presented to the wrong people. ‘Get the right people in the room,’ states Feder. ‘Find out who they are – and be careful, because they are constantly changing.’*

# IRIS: right place, right time

**C**ommunication is vitally important,’ adds Metters. ‘You need clear communication routes and clear shared understanding of expectations. People must know what a positive outcome is. You need to keep people informed and make sure a feedback loop exists to make sure clinical staff are engaged. An agency like ours also requires the ability to produce high-quality literature and respond in a timely manner to enquiries.

‘Most importantly, though, you have to deliver. Identifying the victim is important, but if you can’t translate that into an outcome where somebody gets some help, people will stop referring. GPs expect a lot.’

This final translation of research into practice is a thrill for Feder, as a seasoned researcher. IRIS is an example of a well-planned body of research followed by the challenge of implementing a service that the research team believe should be available nationally: ‘Without the implementation we’d be depressed. We’d rely on the traditional diffusion model with all its failings. We’d go hell-for-leather to publish the papers and disseminate them. We’d approach PCTs, or their equivalent, opportunistically.

‘Instead, we have a proven model – the IRIS programme – that involves training, referral and a referral pathway, and we have a process of lead generation supported by a commissioning package and a training package.’

Despite the prevailing economic climate, Metters is excited by the success of the IRIS programme and even by the changes in healthcare delivery: ‘The new funding world offers us opportunity. We already have a foothold in the world of GPs, following over a decade’s work in domestic violence, and now the IRIS programme. We are potentially in the right place at the right time.’

So far so good, it seems for IRIS. The trial results are positive, the intervention addresses an inadequately met need, and two PCTs are already in the implementation phase of the programme. Health-service research is notoriously hard to translate into practice, but the IRIS programme has made an encouraging start. Implementation will continue to throw up new challenges and more valuable lessons before the IRIS team achieves its vision of national implementation. ■

### *Declaration*

The IRIS trial and implementation programme are both funded by the Health Foundation.

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**'IDENTIFYING THE VICTIM IS IMPORTANT, BUT IF YOU CAN'T TRANSLATE THAT INTO AN OUTCOME WHERE SOMEBODY GETS SOME HELP, PEOPLE WILL STOP REFERRING'**

The Health Foundation wants the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

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