



Responding to violence against women and children – the role of the NHS

The report of the Taskforce
on the Health Aspects of
Violence Against Women
and Children

March 2010

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Chair's introduction – Sir George Alberti



Today, as you read this, emergency departments and dentists will be treating women who have suffered violence at home, GPs will be providing healthcare to children who are victims of sexual abuse, mental health practitioners will be working with service users whose mental health issues have been in part caused by the violence or abuse they have suffered, midwives will be helping women who have been subject to female genital mutilation (FGM) to give birth, and emergency practitioners will be treating patients who may have been harmed simply because they have a disability. For many of the women and children with experience of violence and abuse, the kindness, patience and professionalism of NHS staff make a profoundly important difference to the way they deal with their experience of abuse in both practical and emotional terms. As this report highlights, however, that positive experience is nothing like as widespread as it could, and should, be.

Violence and abuse are experienced by women and children from all backgrounds, and for many their experience remains undisclosed with often devastating consequences for their long-term mental and physical health. It is no respecter of ethnicity, sexual orientation, class or, indeed, age, with the impact of abuse of the elderly often poorly reported. The many NHS practitioners who deal with violence and abuse as part of their daily clinical practice understand the role that violence and abuse play in causing ill-health and distress.

Despite this, we have not seen the same rigorous and systematic approach to this agenda as has been applied to other areas of NHS work such as diabetes or stroke services. Exactly the same need for high-quality care, early intervention and evidence-based practice (and for work to improve the evidence base) applies to the issues addressed in this report.

Increased awareness, training and education are critical for shaping attitudes and providing skills. Leadership at all levels and an outcomes-led approach to commissioning are also essential. Finally, working in partnership with other sectors and agencies is vital when dealing with the complexity of this issue. The success that this approach has brought in other areas of NHS practice should give us both the confidence and the determination to apply the same approach to the NHS response to violence and abuse. And the terrible short- and long-term impact of violence and abuse on the lives of those who experience them serves to reinforce that determination.

It is vital that the Government plays its part in taking this agenda forward, but there is also a great deal that all NHS organisations could do right now. Better provision of information to women and children who have experienced or are at risk of violence or abuse can be achieved relatively quickly and easily. We would like to see board-level questioning of how organisations are tackling these issues, and that could start now. Work to engage women and children locally about the action that is needed could also be started quickly. Sustained action to improve the NHS response to the violence and abuse experienced by women and children is necessary and possible, and should start at all levels of the NHS today.

This is an area where urgent action is needed. It is a disgrace that so little has been done by the NHS so far. I urge the Government not only to accept the report but also to implement the recommendations as a matter of urgency.

Professor Sir George Alberti

Clinical Advisor to NHS London, Senior Research Investigator at Imperial College London and Emeritus Professor of Medicine at Newcastle University

Recommendations

1. NHS staff should be made aware of the issues relating to violence and abuse against women and children, and of their role in addressing those issues.
2. Primary Care Trusts (PCTs), their partners in Local Strategic Partnerships and NHS Trusts should ensure that women and children who are experiencing violence or abuse are provided with information that helps them to access services quickly and safely.
3. All NHS staff should have – and apply – a clear understanding of the risk factors for violence and abuse, and the consequences for health and well-being of violence and abuse, when interacting with patients. This should include:
 - appropriate basic education and training of all staff to meet the needs of women and children who have experienced violence and abuse;
 - more advanced education and training of ‘first contact’ staff and those working in specialties with an increased likelihood of caring for women and children who have experienced violence or abuse; and
 - staff awareness of the associations and presentations of violence and abuse and how to broach the issue sensitively and confidently with patients.

Universities and other providers of education and training, employers, and regulatory and professional bodies should work together to make this happen.

4. Midwives and health professionals should be trained to provide information to mothers from communities which practise female genital mutilation (FGM). Ideally this should take place during the antenatal assessment. The use of targeted questioning in those communities where FGM is practised should be employed as part of an integrated local pathway of care for FGM.
5. PCTs and NHS Trusts should have clear policies on the use of interpretation services that ensure women and children are able to disclose violence and abuse confidently and confidentially.
6. PCTs and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse.
7. Every NHS organisation should have a single designated person to advise on appropriate services, care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk.

8. NHS organisations should have health and well-being policies specifically for staff who are victims of domestic and sexual violence. A clear pathway should be implemented in every NHS-funded organisation so that staff and managers know where and how to access support.
9. NHS organisations should ensure that information relating to violence and abuse against women and children is treated confidentially and shared appropriately. This means that:
 - there should be consistency and clarity about information sharing and confidentiality;
 - staff should be equipped, through training and local support from local leads on violence against women and children and Caldicott Guardians, to share information appropriately and with confidence. In the case of safeguarding children, advice should come from the named doctor and nurse for safeguarding;
 - women and children disclosing violence or abuse should feel assured that their information will be treated appropriately; and
 - the Government should clarify the grounds for public interest disclosure in relation to 'serious crime'.
10. Clear, outcomes-focused commissioning guidance on services for violence against women and children should be issued by the Department of Health, with a particular emphasis on involving women and children in commissioning.
11. Consistent and practical data standards should be agreed relating to the health aspects of violence and abuse against women and children to underpin the analysis of quality, activity, outcomes and performance management by commissioners and NHS and third sector providers.
12. NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure that appropriate commissioning arrangements are in place.
13. Commissioners/PCTs with their partners in Local Strategic Partnerships should ensure that appropriately funded and staffed services are put in place along locally agreed care pathways.
14. The Department of Health and the Home Office should make it clear to the immigration agencies and the NHS that direct treatment needs should be met for women and children experiencing violence and abuse, whatever their immigration status.
15. NHS organisations should ensure that there is sustained and formalised co-ordination of the local response to violence against women and children through a local Violence Against Women and Children Board. NHS

organisations should participate fully in multi-agency fora, such as Multi-Agency Risk Assessment Conferences (MARACs), set up to prevent or reduce harm to victims of violence. These arrangements should link appropriately to local structures in place for safeguarding children and vulnerable adults.

16. PCTs and NHS Trusts should nominate local ‘violence against women and children’ leads, supported by the Violence Against Women and Children Board, to work with women and children and the NHS to drive change and improve outcomes.
17. The Government, PCTs, Local Authorities and statutory bodies should ensure that partnerships with the third sector are outcome-focused, funded appropriately to meet service users’ identified needs, involve women and children, and are supported, promoted and encouraged locally and nationally.
18. Arrangements should be put in place to ensure leadership on this issue across the system – from Ministers and the Department of Health and system leaders, through to Strategic Health Authorities (SHAs), PCTs and NHS Trust boards. Boards should nominate a senior member to ensure that effective services for victims are put in place in line with this report.
19. Regulators of health and social care services (in particular the Care Quality Commission (CQC)) should embed the issue of violence against women and children in their work programme, including registration. The CQC should consider undertaking a special review of how well the NHS deals with the issues highlighted in this report after implementation of the initial Government response.
20. The Government should ensure that clear processes for clinical governance, supervision and regulation are put in place for Sexual Assault Referral Centres (SARCs), and these should be effectively communicated to those managing and working in SARCs and the National Support Team on the Response to Sexual Violence.
21. The Department of Health should work with the relevant regulators and professional bodies to ensure that clinical staff undertaking forensic medical care are:
 - appropriately trained, skilled and experienced;
 - employed by the NHS;
 - integrated into NHS clinical governance;
 - working within a quality standards framework agreed by the Forensic Science Regulator and the Faculty of Forensic and Legal Medicine; and
 - commissioned in sufficient numbers to meet the needs of women and children.

22. A national steering group should be established to oversee implementation of this taskforce's recommendations.
23. The Government should review the evidence base with a view to identifying and addressing significant gaps in the evidence base.

1: Violence against women and children: the role of the NHS

Introduction: why this matters

1.1 The violence and abuse experienced by women and children every day in our society is an urgent problem that must be addressed by all of us, and by our institutions – including the NHS. The numbers are stark:

- 28% of women aged 16–59 have experienced domestic violence.¹
- The British Crime Survey self-completed questionnaire indicates that around 10,000 women are sexually assaulted and 2,000 women are raped every week.²
- 34% of all rapes recorded by the police are committed against children under 16.³
- 16% of children under 16 experienced sexual abuse during childhood (11% of boys and 21% of girls).⁴
- 31% of disabled children have experienced abuse, almost four times the rate of abuse experienced by other children.⁵

- 72% of sexually abused children did not tell anyone about the abuse at the time.⁶ Across the UK there are upwards of five million adult women who experienced some form of sexual abuse during childhood.⁷
- People with a limiting illness or disability are more likely than those without one to be sexually assaulted.⁸
- Some 2.6% of people aged 66 and over living in private households reported that they had experienced mistreatment involving a family member, close friend or care worker during the past year – which equates to about 227,000 people across the UK.⁹

1 *British Crime Survey 2008-2009*, Home Office, 2009.

2 Walker, A, Kershaw, C and Nicholas, S. *Crime in England and Wales 2008/09*, Home Office Statistical Bulletin, July 2009.

3 Ibid.

4 Cawson, P, et al, *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect*. NSPCC, London, 2000.

5 Sullivan, PM and Knutson, JF, *Maltreatment and disabilities: A population-based epidemiological study, Child Abuse and Neglect*, 2000. This is a respected USA study. UK figures are unknown but estimated to be similar.

6 Cawson, P, et al, *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect*. NSPCC, London, 2000.

7 Based on NSPCC study of child sexual abuse – a survey of 18–24 year olds found that 21% of young women and 11% of young men reported experiencing child sexual abuse; the 5 million figure was arrived at by the CIS'ters organisation who applied the NSPCC figures to the 2001 census.

8 HM Government, *Cross Government Action Plan on Sexual Violence and Abuse*, 2007.

9 O'Keeffe, M, et al, *UK Study of Abuse and Neglect of Older People – Prevalence Survey Report*, June 2007. The term 'mistreatment' covers both abuse (psychological, physical, sexual and financial) and neglect. When the measurement is expanded to include neighbours and acquaintances, it rises from 2.6% to 4% (or 342,000 people).

- The UK Forced Marriage Unit receives over 1,600 reports of forced marriage a year and actively deals with over 400 cases.¹⁰
- An estimated 66,000 women in the UK are affected by FGM, with 24,000 young girls at high risk of FGM.¹¹
- Nine out of ten people with learning disabilities experienced harassment or violence within a year.¹² 32% experienced harassment or attacks on a daily or weekly basis. 23% had been assaulted.
- Over half the women in prison say they have suffered domestic violence and one in three has experienced sexual abuse.¹³

1.2 The statistics can only take us so far. Behind each number lie stories of individual trauma and tragedy, and, in many cases, a long legacy of ill-health, both mental and physical.

1.3 The NHS spends more time dealing with the impact of violence against women and children than almost any other agency. Physical and sexual violence and abuse have direct health consequences and are risk factors for a wide range of long-term health problems, including mental health problems, alcohol misuse,

trauma (including maternal and fetal death), unwanted pregnancy (including teenage pregnancy), abortion, sexually transmitted infections and risky sexual behaviour. It is less well recognised that a number of health problems such as obesity and dental neglect due to dental phobia can also be caused by abuse. Action to tackle the causes and consequences of violence against women and children therefore contributes to the health and well-being of the population.

1.4 If violence and abuse against women and children were a single disease that led to the consequences for health listed above, it is likely that the NHS would be far more focused on it than is the case today. Around 60,000 women have a stroke in the UK every year, which has a prevalence of 2–3% in the population. This is – rightly – seen as a critical priority for the NHS, as is dealing with diseases such as diabetes (4% of women in England have a diabetes diagnosis) and coronary heart disease (prevalence among UK women is 4%, with 46,000 experiencing a heart attack each year).¹⁴ We argue strongly that the health consequences of violence and abuse need to be taken just as seriously, and that we should start with an appreciation of the scale of the issue: more women suffer rape or attempted rape than have a stroke each year, and the level of domestic abuse

10 FCO, 2009. Information available at www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage

11 FORWARD epidemiological study, 2007. 'A Statistical Study to Estimate the Prevalence of Female Genital Mutilation in England and Wales', October 2007. Available at www.forwarduk.org.uk/key-issues/fgm/research

12 Mencap, *Living in Fear*, 2000.

13 *Reducing re-offending by ex-prisoners*, Social Exclusion Unit, 2002.

14 See *Heartstats 2008*, British Heart Foundation, chapters on Morbidity and Diabetes, www.heartstats.org/datapage.asp?id=7998; See also *Stroke Statistics 2009*, British Heart Foundation and the Stroke Association, www.heartstats.org/datapage.asp?id=8615

- in the population exceeds that of diabetes by many times. The same effort to ensure that a heart attack victim or a stroke patient gets rapid and appropriate care should be applied to the victims of violence and abuse.
- 1.5 For many women and children who experience violence and abuse, NHS settings often represent the one place where it is possible to talk to someone about their experience without discovery or reprisal from the perpetrator. The NHS response to women and children who can be isolated and fearful as a result of their experience is critical to their future well-being. In some cases, the way NHS staff behave after a disclosure can mean the difference between life and death; and while most cases are not as extreme, it remains true that for those women and children who do disclose their experience, the initial reaction of the person they tell and the follow-up within and beyond the NHS (including, where appropriate, in the criminal justice system) can have a profound effect on their ability to re-establish their life, health and well-being.
- 1.6 Survivors of sexual abuse can also experience re-traumatisation in their response to treatment and care which unintentionally triggers or reawakens early experiences of abuse (eg close quarters observation or the administration of medication). Health practitioners, such as those providing health screening procedures including cervical cytology, dentists, opticians, maternity staff and others, need to be aware of this possibility, and take steps to respond appropriately.¹⁵
- 1.7 Women and children with disabilities who have experienced long-term physical and sexual abuse may also be traumatised and more vulnerable to mental health problems. They may have trouble communicating what they have been through and this can lead to challenging behaviour. This may be incorrectly identified as a symptom of their disability or as a general deterioration in their behaviour. NHS staff need to appreciate the complexity of both early identification and disclosure for disabled victims of violence.
- 1.8 The way the NHS responds to women and children who are experiencing or have experienced violence and abuse is also a test of how well it is living up to the values and principles it set for itself in the NHS Constitution. A National Health Service that 'provides a comprehensive service ... irrespective of gender', which 'has a duty to each and every individual that it serves and must respect their human rights' and which numbers 'compassion' and 'respect and dignity' among its values must be a service that takes seriously the needs of women and children experiencing violence and abuse.¹⁶

15 See *Mainstreaming Gender and Women's Mental Health*, Department of Health, 2003.

16 See www.dh.gov.uk/en/Healthcare/NHSCConstitution/index.htm

1.9 In short, as a matter of normal humanitarian principles, core values, social responsibility and its basic mission to make people healthier, the NHS has a critical role to play in relation to violence against women and children.

The aims of the taskforce, the wider context and our evidence base

1.10 The extensive consultation *Together we can end violence against women and girls* carried out for the Home Office in 2009 highlighted that the NHS needs to do better in responding to victims of violence and abuse. We were asked to look specifically at the role of the NHS in meeting the challenge of violence and abuse against women and children, including the treatment and support of victims of violence and the role of the NHS – in partnership with other agencies – in preventing violence and abuse against women and children. The work of the taskforce forms part of the broader cross-government programme led by the Home Office to tackle violence against women and girls.¹⁷ The terms of reference of the taskforce are set out at Annex 1.

1.11 In developing this report, and as part of our evidence-gathering strategy, we have taken the cross-government programme

into account, together with the important principles enshrined in the UN Convention on the Elimination of All Forms of Discrimination against Women and the UN Convention on the Rights of the Child. Violence against women is a cause and consequence of gender inequality and it is clear that it is unacceptable that women and girls in our society are vulnerable to abuse. We recognise in writing this report that gender is also vital to understanding the way in which violence and abuse impact on the individual. It is clear from the literature that the way in which each individual deals with violence and abuse is mediated by a number of factors, including their gender, sexual orientation, age and the variety of factors that underpin individual resilience. It is also important to recognise that violence and abuse can occur in relationships irrespective of sexual orientation.¹⁸ We have taken account of the relevant statutory equality duties, and particularly those provisions relating to the need to eliminate unlawful discrimination and to promote equality of opportunity; and of the Beijing Declaration of the Fourth World Conference on Women (1995).

1.12 We have looked at a wide range of evidence from a number of

17 As the taskforce sub-groups worked through the issues, it became clear that, in the context of the NHS response to violence against women and girls, it was almost always impossible to draw helpful or meaningful distinctions between the needs of girls and those of children more generally. We have therefore looked at children rather than girls in isolation.

18 A study of intimate partner violence in same-sex and heterosexual relationships identified that of those who responded that they were currently in a first same-sex relationship, just over a third (34%) had experienced domestic abuse. Hester, M and Donovan, C, 'Researching domestic violence in same-sex relationships – a feminist epistemological approach to survey development', *Lesbian Studies*, 2009.

sources. We also commissioned a rapid review of the literature, which the authors may publish separately. It is clear that there are significant gaps in the evidence base from which we were able to draw, particularly in the area of the effectiveness of therapeutic interventions for victims of some forms of abuse or violence. The research and statistical evidence that we have gathered has given us a sense of the scale and different forms of violence against women and children. The testimony of individual women and children that we have been privileged to hear through this process dramatically adds to that sense of scale some understanding of the profound human consequences of violence – including the impact on health and well-being. We have also learnt a great deal from some perceptive focus groups that captured the views and feelings of NHS staff. In relation to women and children with disabilities who have suffered violence, we have collected evidence from the national lead for disability hate crime.

- 1.13 Violence and abuse against women and children take many forms, and to support the work of the taskforce steering group, four sub-groups were set up covering:
- domestic violence;
 - sexual violence against women;
 - child sexual abuse; and
 - harmful traditional practices (including FGM, forced marriage

and honour-based violence) and human trafficking.

- 1.14 Each sub-group has produced a report, which has fed into the development of this final report. The sub-group reports will be published separately.
- 1.15 We are grateful to the participants in the sub-groups for their commitment and insights.¹⁹ While many of the themes identified in this report are common across the sub-group areas, the work of the sub-groups has greatly enriched our detailed understanding of the issues for different women and children facing different forms of violence and abuse, and makes us confident that our recommendations are robust.

Conclusion

- 1.16 This report describes the key issues identified by women and children themselves (Chapter 2), and by NHS staff as well as by experts from a wide range of interested bodies. It sets out a number of recommendations to address these issues (Chapters 3–6).

¹⁹ Available at www.dh.gov.uk/vawc

2: What women and children told us

How we gathered our evidence

- 2.1 The taskforce commissioned the Women's National Commission, an independent advisory body on women's issues to government, to undertake a series of focus groups that built on earlier work to inform the cross-government consultation on the Home Office's strategy, *Together we can end violence against women and girls: a consultation paper*. Fourteen focus groups were held between September and November 2009 across England. These involved a total of 211 women from a range of backgrounds, including women from black and minority ethnic communities who have experienced domestic and/or sexual violence; women who have used statutory mental health services; women refugees and asylum seekers; disabled women; older women; and those who have been identified as victims of domestic violence, rape or sexual assault, sexual abuse and/or incest, and honour-based violence.
- 2.2 The taskforce commissioned a study which asked for views from children and young people about their experiences in seeking and/or receiving help from the NHS after suffering sexual violence or abuse. Wherever possible, feedback was gathered from children within their existing therapeutic relationships; and some young people participated in focus groups. Sixty-five children contributed their views to the consultation. They were receiving services from a range of agencies offering recovery services in the community to children who are victims of sexual abuse (including new technology abuse), sexual violence and exploitation (including trafficking), and mental health services (both NHS and third sector).
- 2.3 We also worked with a number of NHS organisations to gather the views of NHS staff. In October 2009, a deliberative event was held in Birmingham with local NHS clinicians and managers to discuss local issues and the role of the NHS in supporting women and children who are experiencing or have experienced violence or abuse. Additionally, a number of NHS demonstration sites (an ambulance trust and three other providers) are working on projects relating to this agenda, including, for example, how best to support NHS staff who are themselves victims of violence or abuse.
- 2.4 The discussions with women and children who have experienced violence and abuse and with NHS staff produced a rich variety of evidence. Four key themes emerged:
- Prevention and awareness.
 - Safe spaces with staff who listen, understand and help.

- Using information well – and safely.
- Right services, with the right people, in the right place, at the right time.

Prevention and awareness

- 2.5 A strong message from the focus groups was the need to influence public attitudes and to start early in schools. While this is largely beyond the remit of this taskforce, there are ways in which public health staff (including school nurses and health visitors) can work in partnership with schools on this agenda.

“Children need to be taught about healthy relationships. Health services should be focusing on promoting healthy relationships from a very young age, then they wouldn’t have to deal with the effects of so much violence and abuse later on.”

- 2.6 The focus groups also stressed the need to raise awareness among NHS staff.

“Health professionals see their role quite narrowly. You get the sense they don’t see responding to violence against women as part of what they do. But this should

be the main part of what they do, responding to it and preventing it happening; it has a huge impact on women’s health, physically and mentally. Health services need to see their role more widely and offer a holistic approach to violence, to respond to the root cause of women’s health problems, which is usually violence.”

“GPs’ understanding of forced marriage or honour killing is not good. They don’t pay attention to domestic violence, and know nothing about forced marriage and violence committed in the name of honour. Some may take it seriously, but not all. We need GP training on these issues, and more information about violence and the help available, in different languages, needs to be in every GP surgery in places where women can safely pick it up.”

Safe spaces with staff who listen, understand and help

- 2.7 The focus groups emphasised the enormous importance of the way NHS staff behave – sensitivity, understanding and a willingness to listen were critical.

“Within health services, I had a fantastic consultant – he was really polite, I was in the waiting room and the doctor came over with my notes, he shook my hand and asked if I would like to come with him. I felt immediately he would understand about my experience. I felt like I had control over my decisions – he asked me how I felt about everything and gave me choices. I was in control.”

“It needs to be asked at the right time, and sensitively. It needs to be safe, the perpetrator might be with them, it’s about getting that brief period of time when they can be on their own. And it’s a case of being able to trust someone immediately. It’s about taking that risk, asking, then knowing how to respond

when a woman tells them what’s happening.”

“I go down to the children’s centre, and they have a system set up with a midwife who’s doing antenatal care down there. In the toilets there, when women do their water sample, there are little stickers that you can stick on the water sample that then indicate to the midwife if you want to be seen separately if you’ve been abused, because they are colour coded; this is especially helpful if you’re there with a violent partner who’s following you everywhere. So when you go to the toilet you can just put this little sticker on and then the midwife is aware and knows the situation. But I don’t know if that’s the same everywhere.”

- 2.8 And when NHS staff fall short, the impact can be devastating.

“Health services don’t believe you when you try to get help. I was raped and went to my doctor. He was useless, and

made me feel like I was to blame. The GP wrote 'raped' in inverted commas on my notes, which said everything about his attitude to women who've been raped. But then this affects everything else too. When my case went to court, it got thrown out on the basis that the GP didn't believe me! I was really upset, I still am."

- 2.9 For many staff, making the right judgement can often be a difficult balance, fraught with uncertainty.

"Coming out of there, with three hours drive back, thinking about that woman I've left. I wish she was in the car, driving back. Then having to think about that decision I've made."

- 2.10 NHS staff also raised the issue of the impact on their relationship with patients who are victims of violence and abuse when staff themselves may have experience of violence or abuse.

"With that prevalence, you will get staff who are currently or previously experiencing violence: they may think 'I

don't want to talk about it because that's an issue for me'."

Using information well – and safely

- 2.11 The safe and effective use of information was raised by many of the participants in the focus groups. This is an area requiring fine professional judgement: on the one hand, sharing information could safeguard a child from harm; and on the other, protecting confidentiality could mean the difference between life and death for a woman. When it is done well, it can make the experience that someone has of the NHS extremely positive.

"Confidential health services where women can go to tell of their concerns, without family members getting to know what she's said, is very important. We know many women who have had their confidentiality breached through GPs who have good links with local communities. A woman who was threatened with 'honour' killing spoke to her GP about her concerns through an interpreter, who was a friend of the family. They passed

this information she gave him back to the family, and she got killed as a result.”

“[The] hospital was excellent – my husband had come to visit my son in the hospital after the little one had his operation and the doctors removed all his notes from the bed because I’d warned them he was coming, and they warned me when he arrived and made him wait and asked me if I was alright for him to see my son now. They were brilliant with me, they made sure my new address wasn’t anywhere so he could see it.”

- 2.12 For some of the participants in focus groups, more effective communication between services was important, and others emphasised the need to ensure that women can control who knows about the violence or abuse they have experienced. Children said that how information is shared is important.

“Better communication across health services is needed. Like there’s no link between the hospital and the GP, or between mental

health services and the GP. The A&E are supposed to fax over to the doctors what has happened to you. But it’s whether they act on this information. I don’t think they record why I’m there or what’s happened even though I told them I’d been abused. I don’t know if my GP knows or not.”

“I don’t think it should be in my maternity notes that I have fled domestic violence and that I’m in a refuge, which it actually does. I could lose my notes and someone could find them. I want it somewhere saved on a computer so it can’t get lost. I’m not ashamed of what’s happened to me but I want control over who knows.”

“When I told my LAC [Looked After Children] nurse she listened to me carefully and believed me. She told me what she was going to do and let me hear her on the phone talking to the police.

She even checked with me that she had reported what I had said properly. She didn't take over ... just explained what would happen. I told her because she was the only person I trusted to tell ... She's always been there for me."

Right services, with the right people, in the right place, at the right time

2.13 Finally, the focus groups emphasised the importance of services that are accessible, sensitive and which genuinely meet their needs. In many cases they might not be provided within the NHS itself, but through referral to third sector organisations with expertise in advocacy and specialised services. A number of the women who took part also spoke of the need for female staff to be available. The particular needs of people who have experienced violence or abuse as a result of their disability also should be understood and met. The needs of older women were also highlighted.

"I saw a counsellor through my GP, which took ages and then only lasted a few weeks, which didn't give me time to open up about the abuse. I then got referred to ... [rape

crisis], who help me for as long as I need it. It's great they're here whenever you need to talk."

"The first person that believed me was a worker in the 16–19 team at CAMHS [Child and Adolescent Mental Health Service]."

"Counselling and the Brook were the things that helped me most."

"There needs to be more support for my mum and other mums who are in the same boat ... she was really upset when I first told my teacher and seemed cross with me and worried for me all at the same time."

"The real problem for disabled women who have to flee their home in the middle of the night to escape violence is that they need a certain package of care, like PA (personal assistant), dialysis or respite facilities, but the

care doesn't go with you. You often have to move very quickly to get into a refuge like my mother and I did when we had to flee violence when I was 12. You have to start again and it can take months and months to get in place the care that you need and you could be totally dependent on PA or a carer. There needs to be a named person, a key contact, in each area, or each hospital, who is designated to helping you. You ring your GP or the hospital and they don't know. I imagine this is the same situation for those on chemo or long-term medication. You're in a situation where you need a carer and you can't even make a cup of tea on your own."

"You're on a conveyer belt in the health service and they don't really care, especially if you're an older woman I find they don't take you seriously. Especially in hospitals. They think, 'Oh it's your age'. The nursing staff have no idea

how to treat patients with dementia. You are not treated as a person ... I went in to hospital and had to sleep in my wheelchair for four nights because they had given away the only disabled-accessible bed."

"Amongst older women there is still little awareness that rape in marriage is violence and a criminal offence and it's very difficult for anyone to go to a health professional and report it or to get help from the sexual abuse. There needs to be more awareness raising amongst older women, and support from social care and health support workers."

2.14 In the space available in this report, we have only been able to provide a small sample of the material we have drawn upon, but even this relatively short set of examples demonstrates how vital it is for the NHS to get it right for women and children who have experienced violence or abuse. We are publishing the full reports separately.²⁰ The broad conclusions of the Women's

²⁰ WNC, available at www.thewnc.org.uk/publications/cat_view/90-violence-against-women.html

National Commission (WNC) focus groups have given us a number of useful indicators of where action could be prioritised:

- Health services should focus more on prevention.
- Cultural and attitudinal change is needed in the NHS.
- Healthcare professionals should be trained in identification of the signs of violence and abuse, how to respond sensitively and signpost victims appropriately to other services.
- There should be a national public health campaign on violence against women and girls.
- The NHS should deliver culturally sensitive services to women in their own language if possible or through trained professional interpreters that are not from their local community.
- All health services should have clear protocols for maximising confidentiality and safety when making referrals, and for consensual information sharing with external agencies, if violence is disclosed.
- the benefit of counselling – as and when the child wants it and not necessarily in a CAMHS unit;
- the need for training and education of health workers;
- the lack of independent advocates for children – when a child had an independent advocate, it was reported that this proved to be pivotal in their recovery;
- LAC (Looked After Children) nurses, who were singled out in three responses as being crucial to the children concerned. Those children supported by their LAC nurses felt the benefit of having an advocate who was by their side throughout the disclosure process; and
- insufficient education and awareness raising regarding child sexual abuse within schools, health clinics, youth clubs and other settings that children encounter during their childhood. This results in little signposting for children to assist them in finding someone to help them.

2.15 The key findings from the consultation with children have also proved helpful in shaping the thinking of the taskforce on:

- children not being believed by professionals;
- professionals not asking children directly if they have been harmed;

2.16 The rest of this report takes the themes that have emerged from our consultation process and recommends action under each of them.

3: Prevention and awareness

“Sexual abuse should be made more public and health should see it as a public health issue and raise awareness about it. Health services are helping abusers by keeping sexual violence a secret; it should be out there so everyone – women and children – feel they can tell someone if it is happening.”

- 3.1 A clear message from the women and children we engaged with through this process and from NHS staff concerned the responsibility of the NHS to play its part in preventing violence against women and children. As stated in both the 2010/11 Operating Framework and the recent Department of Health strategy document *NHS 2010-2015: from good to great. Preventative, people-centred, productive*,²¹ prevention is a key strategic aim for the NHS. We would therefore expect that work to develop and implement policy on prevention takes explicit account of the potential health and well-being benefits of preventative action in relation to violence against women and children.
- 3.2 Prevention can be primary (preventing violence and abuse before it happens), secondary (preventing further violence and abuse in those at risk of it) and tertiary (managing the long-term physical, psychological and social consequences of violence and abuse). The three levels of prevention require an awareness of both the different forms of violence and abuse and the ways in which they can be addressed. A great deal of primary prevention requires multi-agency interventions on a societal and community basis rather than a direct NHS response. Awareness of the issues needs to be increased among both the public and NHS staff (though it is likely to be done very differently according to the audience). It includes understanding the role of gender as a cause of violence and abuse, and its influence on

²¹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109876

the attitude of victims. We address secondary prevention in Chapter 4.

Primary prevention

3.3 Prevention aims to stop violence before it starts, through identifying need, intervening early, addressing wider determinants and working in partnership. A range of evidence suggests that needs-based public health approaches, based on intervening early and tackling the wider determinants, can be effective in violence and abuse prevention. They include:

- identifying children and families at risk or in need of support;
- improving maternal mental health;
- raising awareness of the heightened risk of violence and abuse faced by people with disabilities;
- working with and supporting parents and families through parenting programmes and family interventions, eg Family Intervention Projects and Family Nurse Partnerships;
- working with schools to promote good mental and emotional health, and violence and abuse prevention skills;
- community-based approaches;
- promoting safe and equal relationships among young people;
- early identification and treatment of conduct disorders in children and young people;

- reducing alcohol consumption in children, young people and adults;
- reducing social and economic as well as health inequalities; and
- sharing information across agencies to identify victims and those at risk.

The benefits of violence prevention are likely to span several sectors. Interventions carried out in one area may improve outcomes in another. Collaborative approaches to identify the distribution of costs and benefits may also support the delivery of prevention across partnerships, although it is accepted that the NHS will be a relatively minor partner in many of these areas.

3.4 Some of the most important causes of violence and abuse against women and children are those attitudes (held by men, women and children) that can motivate, and can be seen by some to justify, abusive behaviour. The way in which both perpetrators and victims of violence and abuse perceive it – in some cases normalising and accepting it – needs to be understood in the context of current social norms. According to a poll conducted by Amnesty International in 2005, there is a ‘blame culture’ regarding attitudes to sexual violence, as more than a quarter (26%) of those asked said that they thought a woman was partially or totally responsible for being raped if she was wearing revealing clothing. Similarly, 22% held the same view if a woman

had had many sexual partners.²² Attitudes of this kind are often formed at a very young age and then reinforced by everyday behaviour. We see a particularly important role for schools and the NHS staff who work with children and young families in challenging the underlying attitudes that promote and permit violent or abusive behaviour towards women and children. We also see an important role for alcohol education programmes in schools, given the role that the misuse of alcohol plays in many cases of violence.

“My daughter ... not very long ago had her two front teeth knocked out by her partner who head-butted her. She was taken to A&E, and was treated really carelessly by the medical staff there. It was all very rushed, they were brusque and didn’t ask her about domestic violence at all. They referred her to a dentist, who didn’t ask her about the domestic violence either ... She had a long course of dental treatment because of the damage he’d caused, and still no one asked her about the domestic

violence, how it happened, let alone referred her to anywhere that could help her. It was all very perfunctory, they were treating this injury, responding to the fact she needed new teeth; that was all ... I believe that if health had addressed it early on, she might have been able to get out of the relationship a lot earlier, and the impact on her and her child, which has been dreadful, would have been less.”

- 3.5 There is a pressing need for a comprehensive and inclusive communications strategy, linked to wider communications work concerned with violence against women and children. This strategy should describe how to connect effectively with people from different communities and cultural traditions. Two elements of a communications strategy are particularly important: raising the awareness of NHS staff – and getting them to act on that awareness – and enabling women and children to access services effectively.

²² Amnesty International, www.amnesty.org.uk/news_details.asp?NewsID=16618, November 2005.

“[When you tell them that you have been sexually abused] you need someone to say ‘I believe you’. That’s the most important thing. Anything after that is great. But that’s what screws your head, someone calling you a liar.”

Recommendation 1:

NHS staff should be made aware of the issues relating to violence and abuse against women and children, and of their role in addressing those issues.

- 3.6 It is important that work to raise the awareness of NHS staff is underpinned by evidence and framed in a way that resonates with them, which may well mean tailoring messages for different staff groups. Consistency of message and behaviour is also critical: organisations that tolerate or reward bullying behaviour will lack the credibility to tackle this agenda effectively. In addition, women and children who need to access services require good, up-to-date information in a form that they can understand and use.

Recommendation 2:

Primary Care Trusts (PCTs), their partners in Local Strategic Partnerships and NHS Trusts should ensure that women and children who are experiencing violence or abuse are provided with information that helps them to access services quickly and safely.

“At my GP in Nottingham there was no information, nothing about forced marriage, my doctor just told me to ring the Samaritans. I didn’t know what a refuge was, there was no information – I didn’t know there was anything I could do to change my situation. If I hadn’t gone to the housing agency, I don’t know what I would have done.”

“Advice about the help available needs to be even more subliminal than leaflets in a GP surgery, for some women. I couldn’t have been handed a leaflet without getting a beating when I got back. If I’d been handed a massive booklet of services, that would have been it. It needs to be on places like a lip balm or on a bus ticket or supermarket receipt.”

- 3.7 The communications strategy would highlight the experience of those subject to violence and abuse, and would be co-ordinated with wider communications work (eg to highlight the criminal sanctions for violence and abuse, and to emphasise the evidence of victim experience that shows the importance of being believed when disclosing violence or abuse). It would also include and/or link to messages on disability hate crime and be made relevant and accessible to disabled people.
- 3.8 Much of the communication that is required will need to take place locally. In using communications techniques to raise awareness and capability among staff of both the issues and what they can do to address them, NHS organisations should pay close attention to those issues for which local awareness is particularly low.

Alcohol

- 3.9 British Crime Survey data for 2008/09 shows that 38% of domestic violence incidents (ie more than one in three) were alcohol related.²³ There is a clear (albeit complex) association between the misuse of alcohol and many cases of violence against women and children. Local organisations need to ensure that their strategies relating to alcohol, including the communication aspects of those strategies, also factor in issues of violence and abuse, drawing on the evidence which shows the role of excessive alcohol consumption in disinhibiting perpetrators, and on the evidence of how excessive alcohol consumption can lead to a greater vulnerability to violence.²⁴

²³ According to the 2008/09 British Crime Survey, victims believed the offender(s) to be under the influence of alcohol in nearly half (47%) of all violent incidents.

²⁴ See the 2009 World Health Organization review *Preventing violence by reducing the availability and harmful use of alcohol*.

4: Making the NHS a ‘safe space’ to be heard – and helped

“I’ve been treated as an individual by my GP – he asked me about the abuse, he listened and understood and didn’t reach straight for the prescription pad. He got me 19 counselling sessions on the NHS for depression, which I think is unheard of. Even the nurses and all the staff at the surgery were polite, they took me seriously and supported me. I’ve been with them four years and I could not fault them. I feel properly cared for in the broad sense of the word. I think what was good was they actually had the counselling service at the surgery.”

- 4.1 Women and children were very clear that they wanted:
- safe spaces where it is easier to disclose violence and abuse; and
 - staff who are understanding, believe what they are told and are able to address issues themselves or refer women and children to appropriate services.
- 4.2 The NHS often provides the one setting where women or children feel able to disclose, and it is therefore imperative that the NHS is aware of the need to provide safe spaces for this to happen.
- 4.3 While some women and children experiencing violence and abuse simply want to talk to someone
- This applies just as much to services that do not specialise in treating women and children who have experienced violence and abuse (eg primary care) as to those that do. Commissioners and providers of healthcare need to build in the time and the space for disclosure across services, paying particular attention to the privacy and safety of the relevant parts of their premises, including the need to see people who may wish to disclose violence or abuse alone.

about it, many want the NHS staff they confide in to be able to do something to help – and they should be able to expect that help. It may be simple documentation, direct help or supporting them to find help elsewhere within or beyond the NHS. There are some occasions where this does occur, but in too many places it does not happen as well or as uniformly as it should; and in some cases, the sad truth is that those experiencing repeat victimisation can be dismissed as serial complainers. This is not because staff, on the whole, do not want to help; often they do not know what to do or do not have the confidence to respond effectively. What is needed is a mix of increased confidence and the development of greater capability for staff in supporting women and children experiencing violence and abuse. Good training and staff development will address both.

- 4.4 Violence and abuse can be such a frequent experience for women and children with a disability that they can come to see it as a routine part of their everyday lives. This perception presents a significant challenge for the NHS staff who will treat the patient for the consequences of harmful behaviour. They will also need the capability and confidence to discuss with the patient what has caused it.

Identification and referral: Mid-Staffordshire Foundation Trust

Mid-Staffordshire Foundation Trust is planning to train staff to help them identify the signs of abuse and make them aware of issues surrounding violence and abuse. This will allow staff to communicate sensitively and offer targeted assistance and advice, which will enable individuals to find and access the appropriate support services.

The trust has identified that there is a lack of signposting to available services. Although contact with some local service providers has been made, there is currently no pathway for victims of violence or abuse who present in an acute setting. The trust is planning to work on the development of a specific pathway, which will be incorporated into the trust's wider vulnerability initiative.

- 4.5 Education about violence against women and children should be included in undergraduate training of all healthcare professionals, and at a basic postgraduate level, with advanced training for those specialties and professions most likely to have direct contact with women and children experiencing violence or abuse. This also applies to continuous professional development and induction training. It also needs to be incorporated into reflective practice and supervision, and works best when integrated into other training and development, for example training for alcohol issues and child safeguarding. The training should include understanding of the need to preserve forensic evidence, and

understanding of disability hate crime. There should be specific training for all 'first contact' practitioners, with an emphasis on asking patients about violence and abuse, and an appropriate initial response, including signposting and referral to other services such as expert advocacy.

The role of paramedics – South East Coast Ambulance Service

SE Coast Ambulance Service is developing a toolkit to enable ambulance staff to respond effectively to cases of violence or abuse. This is partly in recognition of the unique position that paramedics are often in compared to other healthcare professionals – paramedics have an ideal window of opportunity when they are alone with patients as they are transported into and secured in the ambulance. The toolkit that the service is developing will build on good practice from their trust and other trusts, and will improve professional understanding and competency in spotting the signs of violence or abuse and in questioning around these in a sensitive manner.

SE Coast Ambulance Service serves a diverse population and the trust will ensure that the toolkit produced is culturally clinically competent, ensuring that seldom-heard groups are accommodated. The toolkit will give ambulance staff the practical skills and training needed sensitively to ask any patient about violence or abuse where signs of these are present. It will also give staff the confidence and personal skills needed to address this issue.

“After I was admitted for anorexia, my dad would come and see me and I would scream ... cos I couldn't cope with it at all and after his visits I would self-harm ... because it triggered flashbacks of things that he's done in the past because of my PTSD [Post-Traumatic Stress Disorder], but it felt like I was going to explode. I just couldn't cope with it. But no one asked me why!”

- 4.6 Central to the capability required of **all** NHS staff is the ability to understand the risk factors for, and recognise the signs of, violence and abuse – not all of which are obvious. Some of the relevant risk factors such as pregnancy (when 30% of domestic violence is thought to start) are relatively well known, others less so.²⁵ Clinicians should be more open to the possibility that violence or abuse is an underlying cause of the problems of the patient in front of them. But this recognition in itself is not enough – women and children told us that staff need to build trust, demonstrate belief in what they are told and discuss options sensitively. This means that practitioners must develop the communication skills (both verbal and non-verbal) to develop trust and enable disclosure. Training

²⁵ For the 30% figure, see McWilliams, M and McKiernan, J, *Bringing it out into the open*, HMSO Belfast, 1993.

and development to improve communications skills need to include cultural competence and consideration of women and children who are less able to communicate because of disability (including learning disability) or, for example, dementia – not least because evidence suggests that people with impaired communication and those with mental health problems are particularly vulnerable to abuse.

“You won’t necessarily go into your doctors and tell them, but I had medical problems being caused by the violence, and maybe if they had training in looking for these sorts of things it might trigger something to make them think domestic violence could be a possibility. If he had asked me, ‘Is there something else happening at home that I should be aware of’, I think I’d have been more likely to say yes and to tell him what was happening.”

- 4.7 Disclosure is the result of a dialogue built on trust and confidence. This requires NHS staff who are able to create a trusting environment and an interpersonal rapport that enables the discussion of sensitive and difficult matters. Good consultations

involve sensitively asking direct questions about violence and abuse as part of the diagnostic and therapeutic dialogue; this is the basis for effective assessment of risk. In some settings and situations, such as mental health assessment and during pregnancy, more routine enquiry (ie asking all women) about violence and abuse has been initiated. We do not think there is currently sufficient evidence to extend routine enquiry to other clinical settings. However, clinicians should have a low threshold for asking about violence and abuse, triggered by a range of presentations, including physical injuries, psychological symptoms including somatising disorders, substance abuse, chronic pain, and recurrent gynaecological disorders. Patient behaviour such as repeat attendance in a general practice or emergency department, missed appointments, self-discharge and repeated ‘non-specific’ admissions should also lead NHS staff to ask about abuse. A policy of systematic ‘clinical’ or targeted enquiry would substantially increase disclosure and is a pre-requisite for improving support to women with a current or past history of violence or abuse. Training therefore needs to focus on systematic and sensitive questioning as part of clinical history-taking, followed by risk assessment.

“A&E staff need training. I mean loads of young people who self-harm are trying to block out the pain of abuse. They should get better child protection training and be talked to by survivors of abuse like me.”

Recommendation 3:

All NHS staff should have – and apply – a clear understanding of the risk factors for violence and abuse, and the consequences for health and well-being of violence and abuse, when interacting with patients. This should include:

- appropriate basic education and training of all staff to meet the needs of women and children who have experienced violence and abuse;

- more advanced education and training of ‘first contact’ staff and those working in specialties with an increased likelihood of caring for women and children who have experienced violence or abuse; and
- staff awareness of the associations and presentations of violence and abuse and how to broach the issue sensitively and confidently with patients.

Universities and other providers of education and training, employers, and regulatory and professional bodies should work together to make this happen.

IRIS: Identification and Referral to Improve Safety

As part of the IRIS (Identification and Referral to Improve Safety) programme, 48 general practices in Bristol and in Hackney, London were randomly allocated into intervention and control groups to test a training and support programme to improve the quality of care given to women experiencing domestic violence. Intervention practices were supported by two 2-hour sessions of practice-based training, electronic medical record prompts to ask about abuse, and resources including posters and cards. The success of the programme depended on a clear, easily accessible referral pathway to a named advocate educator based in local domestic violence services, who worked closely with the practice and was central to the training. Doctors and practice nurses were encouraged to use clinical enquiry, address barriers to conversations about domestic violence, respond with key messages and offer referral to a specialist domestic violence worker. The advocate educators offered feedback to clinicians on their work with clients and provided quarterly audit data on identification and referral across practice teams. All intervention practices increased the identification of women experiencing abuse, and referrals. The trial has now ended and the findings, along with a cost-effectiveness analysis, will be reported in 2010. The IRIS programme will be configured so that it can be commissioned by Primary Care Trusts (PCTs) from domestic violence specialist agencies.

For further information, contact: medina.johnson@nextlinkhousing.co.uk or AHowell@niaproject.plus.com.

- 4.8 In the case of female genital mutilation (FGM), the balance of risk and evidence leads us to conclude that targeted questioning in those communities where there is evidence of its prevalence can be justified. Provision of information to mothers from communities where FGM is practised is vital. This discussion must be recorded in the obstetric notes. Some women book late or not at all, and so information in these cases should be given in the time between birth and discharge from maternity services. In the event of delivery of a daughter, the fact that the mother has had FGM must be recorded in the child's 'red book' and this information passed on to the GP and health visitor.

Recommendation 4:

Midwives and health professionals should be trained to provide information to mothers from communities which practise female genital mutilation (FGM). Ideally this should take place during the antenatal assessment. The use of targeted questioning in those communities where FGM is practised should be employed as part of an integrated local pathway of care for FGM.

- 4.9 A communication issue that has come up many times is interpretation for women and children who are unable to speak English. For many of the most vulnerable women and children who turn to the NHS for help, the way an interpretation service is run can make a big difference. In many cases it is still a relative or friend – who may be the person carrying out the abuse – who acts as interpreter. Even in situations where an interpreter is commissioned by the NHS organisation, there is the possibility of breaches of confidentiality if the interpreter is drawn from the same local community. It is vital that objective, appropriately qualified and independent interpreters are always used, which may, in some cases, require the use of services such as 'Languageline'.

Recommendation 5:

PCTs and NHS Trusts should have clear policies on the use of interpretation services that ensure women and children are able to disclose violence and abuse confidently and confidentially.

“Even if the perpetrator isn’t with you, he sends one of his family members with you. And in the name of honour you can’t even talk about it. Especially if they say, ‘I’m going to interpret because she can’t speak English’. That’s why it’s so important that at my surgery we have a language line, because they don’t really like to have people translating because they might misinterpret, so they set up this language line, which has access to all different languages. It’s like a three-way conversation and I think it’s brilliant and maybe the NHS should use this as standard.”

“Just like you have an infection control nurse in each ward, you could have one person who is trained in dealing with domestic violence on each ward and at each surgery. They should be responsible for updating other professionals on new developments in violence

against women, so that good practice is upheld.”

- 4.10 Our work with NHS staff in particular made it clear that there is a strong relationship between the confidence of staff in enabling someone to disclose abuse and the existence of clear referral points within and beyond the NHS. Very often the help that is required is not healthcare at all but may be to do with housing or criminal justice, and frequently is most effectively accessed through third sector advocacy services.²⁶ If staff are not clear what they can do for a person who is suffering or has suffered from violence or abuse, they are much less likely to be open to disclosure. This applies with particular urgency to issues of immediate and significant risk, where it is often the case that women have few opportunities to disclose and prompt action is critical.
- 4.11 While procedures for addressing abuse in children are clear and fairly well understood in the system (though there is still room for improvement), the NHS appears to be less confident in dealing with violence and abuse of adult women.²⁷ There are two elements to doing this well: clearly defined pathways; and people in the right place at local level to provide

²⁶ In the case of therapeutic services for children and young people who have suffered sexual abuse, there is a large gap between need and provision. See *Sexual abuse and therapeutic services for children and young people. The gap between provision and need*, NSPCC, 2009.

²⁷ Of course, many of the women who are victims of violence or abuse also have children who are at risk; in such cases where a woman with children is at risk of harm, child protection procedures should be applied.

advice and 'navigation'. This means co-ordinator/lead posts in every hospital and community-based service and within PCTs. Their role would be to act as a first point of contact for other staff. This would include training staff and raising awareness of violence against women and children, promoting identification and action by health professionals, risk assessment, and signposting or referral to specialist support services, either in the third sector or in the NHS (for instance psychological services with trained specialists in violence and abuse). They should have access to funding and a role in decision-making about service delivery. They should lead a safety-based approach by ensuring that staff within their service are able to provide safe enquiry linked to referral to appropriate services, and safe discharge.

- 4.12 In some instances, a woman will decide to go back to a risky situation, and staff need to know what to do in such a case. We look to the Department of Health to ensure the collection and dissemination of models of good practice and 'model pathways', including international evidence of what is successful.

"There needs to be more places like this [a project run by a non-governmental organisation] where they don't cancel your appointments altogether if you miss one appointment ... the NHS counsellor chucked me off his books for missing two appointments ... you'd think he would understand. But no, I got this official-looking letter ... telling me my sessions had stopped."

Recommendation 6:

PCTs and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse.

Recommendation 7:

Every NHS organisation should have a single designated person to advise on appropriate services, care pathways and referrals for all victims of violence and abuse, providing urgent advice in cases of immediate and significant risk.

- 4.13 Violence and abuse are not just things that happen ‘out there’. As in all walks of life, there are NHS staff who have experienced or are currently experiencing – and perpetrating – violence and abuse. The NHS needs to recognise this, and put in place the necessary support and human resources processes for dealing with it, including opportunities for disclosure and people that staff can confide in. This is an essential element of improving the NHS response to violence and abuse, and the role of NHS Employers as a founding member of the Corporate Alliance Against Domestic Violence provides an important foundation to build upon. For staff who are dealing with patients where violence and abuse are an issue, access to independent counselling is an important source of support.

“Staff need to know that the NHS will support them, will help them, and be open about it ...”

- 4.14 From the consultations and from evidence from the Healthcare Commission²⁸ we are aware that there are, sadly, examples of patients being victimised by NHS staff in care settings, particularly those who are already vulnerable (due to disability, lack of capacity or infirmity). We hope that more stringent requirements to vet staff working with vulnerable adults and children will help to reduce the risk of this happening. This will require a robust approach, which ensures that the safety both of staff who are whistle-blowing and of victims is supported appropriately.

“You will get staff who are currently or previously experiencing violence: they may think, ‘I don’t want to talk about it because that’s an issue for me’.”

²⁸ See *Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust*, Healthcare Commission, 2007, www.cqc.org.uk/publications.cfm?widCall1=customDocManager.search_do_2&ttl_id=2&top_parent=4513&tax_child=4574&tax_grand_child=4575&tax_great_grand_child=4601&search_string=

Supporting staff in west Essex

West Essex Community Health Services are developing a project funded by the Department of Health aimed at supporting staff who are victims of violence or abuse. This was informed by feedback from four focus groups that were held with local staff in west Essex to gather opinions and to determine the local need.

Participants highlighted a lack of awareness of violence and abuse among staff in the workplace, and a lack of knowledge on how this issue should be handled. West Essex is therefore planning to raise the profile of violence and abuse by, for example, including the issue in staff induction sessions. They are also planning to roll out training for all staff and managers, so that they are aware of what constitutes violence or abuse, and how to spot the signs of these. Training for managers will focus on how best to support staff and on how to make the person experiencing abuse or violence feel empowered instead of weak.

A confidential, anonymous phone line that is outside the immediate organisation will be set up, so that staff can self-refer to this, or colleagues or managers can also signpost staff to the service. Staff felt that the phone line should cover a range of issues, so as not to create a label of a 'violence helpline'. It was felt that there is a stigma attached to abuse and violence that can be overcome by discussing the issue openly and incorporating it into existing policies and procedures, instead of creating new ones, which is what west Essex plan to do.

Recommendation 8:

NHS organisations should have health and well-being policies specifically for staff who are victims of domestic and sexual violence. A clear pathway should be implemented in every NHS-funded organisation so that staff and managers know where and how to access support.

5: Using information well and safely

“Communication is key – things aren’t fed back from one another between different professionals seeing the same patient, and within health services, midwives, nurses, consultants, doctors, dentists, no one communicates with each other. This should be done with women’s consent, but it would help prevent women repeating their story over and over again.”

- 5.1 Women and children told us that they wanted information to be used safely and confidentially, and that information should be shared effectively within the NHS and with other agencies. The consultation processes that we have drawn upon highlight the complexity that underlies this basic aim. In some cases women wanted the right not to have information about them shared with other healthcare professionals or other agencies (information concerning whereabouts figured as a particular concern for obvious reasons). Equally, we know that in other cases a lack of sharing information has resulted in the death or serious harm of a child or adult.
- 5.2 For information to be shared effectively, we need to have the following in place: clear national guidance and staff who understand the guidance, either directly through training or indirectly through reliable sources of advice, and who feel confident in their organisation’s position on information sharing. There is often a temptation to focus on the guidance rather than the capabilities of those individuals and organisations required to implement it, but in this case we think that should be resisted. While there are issues that could be clarified, it is our view that the biggest gains could be made most quickly by focusing on improving understanding of what to do when violence or abuse is disclosed, including how to manage risk effectively. This encompasses both the legal position and the more practical (and locally variable) questions of where women and children experiencing violence or abuse can go for further support.

“I hadn’t had an experience of abuse for two years. My midwife asked about abuse just after I’d had a C-section. I told the midwife about the historical abuse and said this isn’t going on now, so can it just be between you and me and she said yes. But then she contacted other agencies, social services became involved. Social services rang bells for me; I have an image of my children being taken away. I don’t understand why they chose that time, just after giving birth, to talk to me about it, but I felt violated, I had just had a C-section and they went and breached my confidentiality. I just wanted to go home. Health workers need to be better trained about abuse and about when to refer to other agencies.”

- 5.3 The key guidance material on information sharing is designed to assist health professionals in making judgements which respect patients’ privacy, autonomy and choices but that also benefit the wider community of patients and the public. It includes the following documents:

- the General Medical Council’s guidance: *Confidentiality* (GMC, 2009);
- the supplementary GMC guidance and *0–18 years: guidance for all doctors* (GMC, 2007);
- *Confidentiality: NHS Code of Practice* (Department of Health, 2003) – which includes supplementary guidance on public interest disclosure that is currently being revised; and
- *Information Sharing: Guidance for practitioners and managers* (HM Government, 2008).

- 5.4 Confidentiality, subject to the requirements of the law, is clearly an essential part of both ethical clinical practice and key to developing the trust of service users who may want to disclose abuse. This is not simply about following the rules; it is also critical that practitioners are able to explain clearly to women and children what their choices are, and what information practitioners are legally obliged to pass on.²⁹ This includes an understanding of the rules relating to competence and children.

- 5.5 The question of whether a health practitioner may share information even when it is not possible to obtain consent rests largely on whether or not disclosure can help to detect, prosecute or prevent a

²⁹ One area where there is scope for a broader and better understanding of the rules is in relation to ‘S flagging’, which provides a basis for patients to consent to a sensitive record indicator (the ‘S flag’) being placed on their record to prevent casual access in cases of, for example, domestic violence.

‘serious crime’. Greater clarity on where public interest disclosure should apply would be welcome.

- 5.6 However much guidance there is, it is clear from the myriad examples relayed to us in the consultation that every case is unique. It is therefore essential for each case to be looked at on its merits and the individual risks of sharing information weighed up against the possible consequences (for the woman or her children) of not sharing. The algorithms set out in key guidance should be widely available and followed, and women should be given an explanation in every case where it is considered necessary to disclose without her consent.
- 5.7 Health practitioners need to be supported by trusts and Primary Care Trusts (PCTs) to make the right decisions about information sharing based on the specific details of individual cases and interpretation of relevant guidance. The taskforce is aware that the level of support available to health practitioners is inconsistent. We therefore believe it is important that staff should be able to consult both the PCT-level ‘violence against women and children’ leads as well as Caldicott Guardians to support decision-making in particularly difficult cases. In the case of child safeguarding, advice should come from a named doctor or nurse for safeguarding.

Recommendation 9:

NHS organisations should ensure that information relating to violence and abuse against women and children is treated confidentially and shared appropriately. This means that:

- there should be consistency and clarity about information sharing and confidentiality;
- staff should be equipped, through training and local support from local leads on violence against women and children and Caldicott Guardians, to share information appropriately and with confidence. In the case of safeguarding children, advice should come from the named doctor and nurse for safeguarding;

- women and children disclosing violence or abuse should feel assured that their information will be treated appropriately; and
- the Government should clarify the grounds for public interest disclosure in relation to 'serious crime'.

6: Right services, with the right people, in the right place at the right time

“GPs should know where to refer women to, so that we get the help and support we need. Health services should work with agencies like them [Rape Crisis], who should be able to go to GP surgeries and introduce themselves and what they do. And they should be funded to hold support sessions there, some kind of drop-in service. They could also do this at the A&E and at other health services where women might go. This would improve the take-up and women’s access to support.”

- 6.1 Women and children told us that they wanted services that are safe, effective, accessible, culturally sensitive, personalised and properly linked to other services – including third sector services. Good commissioning, strong partnerships, leadership and co-ordination, and effective regulation are all essential to achieving these outcomes.

Good commissioning and access to services

- 6.2 Good commissioning requires a detailed understanding of the needs and preferences of the population and of how they can be most effectively (and cost-effectively) met by current and

potential providers within the NHS and beyond. It means being very clear about the outcomes to be achieved. This is particularly important in relation to services that are patchy and variable in quality – as the services to address the needs of victims of violence often are. Commissioning services along pathways across the whole system is central to improving quality and access to good care. It is important that services which address the sensitive and, for some, rarely discussed issues of violence and abuse do so not simply on the basis of hard epidemiological evidence (important as that is) but also by talking to women and children who have experienced

violence and abuse about what they want and expect from those services. The responsibility to commission well is particularly important when commissioning services that specialise in treating women and children who have experienced violence or abuse, but it also applies to more general services such as GPs and emergency departments, which are those most commonly accessed by people experiencing violence or abuse. Commissioning services for victims of violence or abuse is highly complex and requires multi-disciplinary working. This can be done more effectively by using a multi-agency group (the Violence Against Women and Children Board) covering the local area, and commissioners should adopt this approach.³⁰

“We need to make it a statutory duty for all health services to respond to violence against women effectively. There needs to be accountability, a system in place so that health services have violence against women policies and protocols which they implement in every service, with an independent overseer to make sure this happens.”

Recommendation 10:

Clear, outcomes-focused commissioning guidance on services for violence against women and children should be issued by the Department of Health, with a particular emphasis on involving women and children in commissioning.

- 6.3 Again, while there is a great deal of useful information in the public domain already, more could be done to bring consistency to the data in order to improve commissioning, enable comparison and benchmarking, and support further research. This would be particularly helpful to smaller providers, as they are often subject to varying reporting requirements. Having simple, consistent data requirements is likely to have a positive impact on both the costs of collecting and analysing data and the use of data to make genuine improvements in services. The use of anonymous, non-identifiable data in relation to this issue is, of course, particularly important. A number of initiatives, such as the protocols developed as part of the Tackling Knives Action Programme for data sharing between emergency departments

³⁰ For the Violence Against Women and Children Board, see Recommendation 16.

and local police, show what can be achieved.

Recommendation 11:

Consistent and practical data standards should be agreed relating to the health aspects of violence and abuse against women and children to underpin the analysis of quality, activity, outcomes and performance management by commissioners and NHS and third sector providers.

6.4 At the level of service improvement, it is important that NHS clinicians and managers have access to evidence of not only what works, but also of **how** better services can be put in place – case studies of good practice are a particularly helpful way of showing what is possible and how plans were realised. This means planning across the whole system and developing services along appropriate pathways of care. We welcome the fact that the National Institute for Health and Clinical Excellence (NICE) has

been commissioned to produce guidance on domestic violence.³¹

6.5 We believe that there is a strong case for bringing together commissioning expertise on sexual violence services, and particularly Sexual Assault Referral Services (SARS) for children and Sexual Assault Referral Centres (SARCs), using a collaborative, multi-agency approach, linking, for example, to children's trust arrangements in the case of SARS. The majority of SARCs are funded by the police rather than through a joint partnership with the NHS. In order for victims to receive high-quality care, it is important for Primary Care Trusts (PCTs) to be involved in the commissioning of SARCs and for the services to be provided under the auspices of the NHS. This would ensure that the services commissioned were underpinned by clinical governance arrangements and subject to NHS regulatory and inspection frameworks. We would also encourage all PCTs to consider working collaboratively with neighbouring PCTs (and, for SARCs, police forces) when commissioning sexual violence and/or sexual abuse services. This might be through their Local Strategic Partnership, the Strategic Health Authority (SHA), a new or existing consortium or any other arrangements that work locally. The planning, review and commissioning of SARS for children and young people should be: informed by the needs and preferences expressed by children and young people who have

31 See <http://guidance.nice.org.uk/PHG/Wave20/60>

experienced sexual violence and abuse; the best available evidence and expertise; and in compliance with current standards for services for children and young people. These standards are found in: the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric forensic medical services, *Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused* (RCPCH, 2009); the *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills, 2004); and the *You're Welcome quality criteria: Making health services young people friendly* (Department of Health, 2007). Partnership working with women should inform planning and review of services, including SARCs, which form part of the local care pathways for women who have experienced sexual violence or abuse.

Recommendation 12:

NHS commissioners should assess local needs and local services for victims of sexual violence and/or sexual abuse and ensure that appropriate commissioning arrangements are in place.

"I need more support to get over the emotional abuse: which is the worse to deal with. There's nothing out there. If the government is serious about helping us, women who have been through what I've been through should have support to recover from the abuse without having to wait for years, and it should be there for as long as we need it."

“NHS Trusts should develop something like a Well Woman Clinic, which is probably your best bet, if you want to get help because of violence. They’re totally focused on women’s health issues, and you can have women to speak to in a safe environment. Women’s health needs could be met in one place, including addressing violence issues.”

- 6.6 All of the measures outlined above – good data, meaningful consultation, clear guidance, models of good practice – are essential to good commissioning. But they are not enough. Good commissioning also means ensuring that services along appropriate pathways are in place, are well co-ordinated and properly staffed in each area. In short, it is about making decisions and backing them with resources. The priority should be to develop services that are flexible and centred around the needs and the lives of women and children. As with other services, there needs to be a shift towards more personalised provision with multiple access points, putting the convenience of the service user first. This includes focusing on the assessed needs of individual victims, working with them to deliver a package of services that address their personal needs and

wishes rather than standardised packages of care.

“You should have as much counselling as you need, not just the six sessions I’ve been told I can have on the NHS. They think that my childhood abuse can be treated in one session, my depression in the next, the fact that I have a child who is going to die in the next. No one goes because they fancy a chat. They go until they don’t need to go any more.”

- 6.7 Effective specialist mental health and, in some cases, learning disability services are vital to the recovery process for service users who are also survivors of abuse (in childhood and/or adulthood) as these experiences are often a significant contributory factor to their serious mental ill-health. Therapy has been important in supporting the recovery of women and children with learning disabilities who have experienced violence or abuse. The current direction of policy, which seeks to integrate all relevant abuse issues into the full care pathway (including the routine enquiry about abuse in all mental health assessments), is right: the key is moving as swiftly as possible to make this happen.

Recommendation 13:

Commissioners/PCTs with their partners in Local Strategic Partnerships should ensure that appropriately funded and staffed services are put in place along locally agreed care pathways.

- 6.8 For those women and children who have experience of violence or abuse, and who also face issues in relation to their immigration status, accessing the right care in the right place can be doubly difficult. In some cases, there is a reluctance to use NHS services because of anxieties about the consequences for immigration status. While there is clearly a need for clear rules in relation to immigration, it is important that the NHS and other agencies recognise and respond to the vulnerability and the needs of women and children who have experienced violence and abuse, whatever their immigration status.

“I have no papers, no status, and can’t get a GP. At the hospital they said to me ‘go and get a GP’. But I can’t do that. I’ve suffered years of abuse, and had a bad experience recently – I was seriously ill – but I was still not seen by the hospital and they referred me back to a GP. They didn’t try to find out more about why I don’t have a GP. I don’t have access to any healthcare.”

Recommendation 14:

The Department of Health and the Home Office should make it clear to the immigration agencies and the NHS that direct treatment needs should be met for women and children experiencing violence and abuse, whatever their immigration status.

- 6.9 It is important that those commissioning and providing services recognise the diversity of needs and circumstances of

women and children. In particular, there can be wide differences in the services required by those currently suffering violence or abuse and those who are survivors of historic violence or abuse (and for some, of course, there is both current and historic abuse). It is also vital, in those many cases where both a woman and her children are victims of violence or abuse, that the needs of mother and children are met in an integrated and personalised way. Finally, services need to be accessible to women from all backgrounds (eg ethnic groups, any sexual orientation, transgender, people with mental health issues, people with physical and learning disabilities, women of all ages and women from different faith communities) and in a variety of settings (eg urban, rural, for travellers).

Strong partnerships

6.10 It is clear from a whole range of agendas that include the NHS but go far beyond it, such as health inequalities and safeguarding children, that strong partnerships between the NHS and other local organisations (both statutory and non-statutory) can make the difference in meeting the needs of local people. Often, several organisations are working with the same individuals and families, and a more integrated approach can benefit service users and the organisations that work with them. A number of structures are already in place that facilitate local partnership (eg Multi-Agency Risk Assessment Conferences

(MARACs) and Crime and Disorder Reduction Partnerships (CDRPs)). While it is fair to say that NHS participation varies greatly, areas where partnership is strong are often best placed to tackle cross-cutting, complex issues such as violence and abuse.

Good practice example – *Disabled Women and Domestic Violence: Making the Links*

A three-year research project by the Violence Against Women Research Group and Centre for the Study of Safety and Well-being and the Universities of Bristol and Warwick in partnership with Women's Aid was the first national UK study on the needs of disabled women experiencing domestic violence, and the services available to meet these needs. The report noted examples of good practice. **Leeds Inter-Agency Project** was specifically highlighted and praised for its work on embedding the needs of disabled women within local strategic work on domestic violence. This included:

- the incorporation of domestic violence and disability into all relevant plans and strategies;
- all local agencies developing domestic violence and disability action plans (including incorporation into relevant local service agreements);
- the inclusion of the work on disabled women and domestic violence as a minimum standard; and

- graded ‘quality marks’ which agencies attain (eg on accessibility, training and direct service provision for disabled women).

As a result of *Making the Links* (2007), Women’s Aid has developed posters and leaflets to promote awareness of the issues, as well as good practice summary guidance.

For more information on this report, go to www.womensaid.org.uk/domestic_violence_topic.asp?section=0001000100220008§ionTitle=Disabled+women

6.11 There is a robust set of rules and processes in place for shaping the NHS response to child safeguarding linked to Local Safeguarding Children’s Boards and to Children’s Trusts, and this has led us to conclude that there may be merit in the idea of using or linking to that infrastructure in developing a response to the wider agenda of violence against women and children. There is strong evidence of the close link between the violence and abuse suffered by adult women and the risks posed to their children as a result – and of the devastating impact on children of witnessing violence. Similarly, the structures and processes in place for vulnerable adults also appear to offer a useful basis for further work. Any future review of the definition of ‘vulnerable adults’ could present an opportunity to explore whether victims of violence and abuse could be included. Whichever approach local areas take to co-ordinate services more effectively, it is important that the distinct needs

of women and children are recognised and met for both women and children.

6.12 Health services should supply information and education to women and young girls with learning disabilities on what is abusive practice and on how to complain about it. They should work with other agencies to co-ordinate this education and utilise the third sector to provide support. The NHS should work closely with CDRPs, MARACs, SARCs and others to improve sharing of data, collaborative risk assessment and response, leading to increased reporting of crimes and, where appropriate, to successful prosecutions.

Recommendation 15:

NHS organisations should ensure that there is sustained and formalised co-ordination of the local response to violence against women and children through a local Violence Against Women and Children Board. NHS organisations should participate fully in multi-agency fora, such as Multi-Agency Risk Assessment Conferences (MARACs), set up to prevent or reduce harm to victims of violence. These arrangements should link appropriately to local structures in place for safeguarding children and vulnerable adults.

of work done by other agencies to deal with violence against women and children in relation to the NHS. This might include ensuring that training is in place, and working together on a local communications strategy. Again, it would be for local organisations and health economies to decide how to meet this need, but it is clear that better co-ordination of the often isolated local efforts to improve outcomes could produce large benefits if replicated effectively across a health economy.

Recommendation 16:

PCTs and NHS Trusts should nominate local 'violence against women and children' leads, supported by the Violence Against Women and Children Board, to work with women and children and the NHS to drive change and improve outcomes.

6.13 We have been told by some that the NHS is frequently criticised for not playing its full part in contributing to local partnerships such as MARACs and CDRPs. We see major advantages in developing the local co-ordination

6.14 The people fulfilling the 'violence against women and children' lead role would form the natural constituency for populating (and chairing) local partnership arrangements.

“The whole relationship between statutory and third sector services, particularly violence against women services, needs to be reassessed. We in the third sector always struggle to be taken seriously by the statutory sector, particularly by health Trusts and services. We just find engaging with health services incredibly difficult at all levels. They’re incredibly resistant to addressing violence against women ... they don’t invite us to sit around the table, to meetings to talk about services that respond to women’s health, and we can’t get any funding to do this work; it’s not seen that we provide a crucial healthcare response to women who have been abused.”

6.15 As the women and children who contributed to this work have emphasised, the third sector has a particularly important role to play in this agenda, as it is often the non-statutory, women-centred services that they provide that prove most effective in building trust with women and children experiencing violence or abuse. While there are a number of examples of productive working with the third sector, we have also seen evidence of short-term funding that is not Compact compliant, and other examples of behaviour that are not helpful in developing trust and sustainable partnerships, including some ‘contracts’ that carry no money. We are aware of the difficulty facing some third sector organisations at a time of economic and fiscal constraint, with many Rape Crisis Centres, for example, finding it difficult to sustain services in the new environment where they need to compete for contracts from commissioners rather than rely on grant funding. Sustainable arrangements for funding are essential for securing the much-needed contribution of the third sector to supporting women and children who have experienced violence or abuse, and without them the sector faces a real and damaging crisis.

Good practice example – Maze Project, WomenCentre, Calderdale

The Maze Project works with adults at risk of social exclusion where domestic violence is a key feature of the relationship, providing practical and emotional support. It works with women, their partners and their children who have not had the full benefit of the resources that could be available to them, helping the people it supports to identify and navigate through the ‘maze’ of services. The MARAC supports the work of Maze. In cases where the woman has agreed to access support but also wishes to remain in her relationship, the Maze Project may be able to work with her partner. In appropriate cases the team can provide him with practical support and also engage in work to reduce the risk of further harm. The Maze Project is part of a larger domestic violence team at WomenCentre.

Recommendation 17:

The Government, PCTs, Local Authorities and statutory bodies should ensure that partnerships with the third sector are outcome-focused, funded appropriately to meet service users’ identified needs, involve women and children, and are supported, promoted and encouraged locally and nationally.

Third sector–PCT partnership examples:

- Equal partnerships with Rape Crisis Centres such as the South Essex Rape and Incest Centre, Tyneside Rape Crisis and Bradford Rape Crisis – a range of therapeutic and practical support services funded or commissioned with service-level agreements attached; and
- Cheshire and Merseyside: the Rape Crisis Centre played a key role in the development and management group for the SARCs in the two counties.

Leadership and co-ordination

6.16 Ensuring the availability and quality of services is not simply a matter of getting the ‘technical’ questions of commissioning and engagement right. It is also about connecting this agenda with the values and purpose of NHS organisations. The leaders in place throughout the system – from Ministers to Trust Chief Executives – must take responsibility for doing this, driving the agenda forward, and for communicating to those they lead the need to get things right for people experiencing violence or abuse. How leaders do this is a matter for them, but they should be prepared to be held accountable by local people if they are not seen to be leading on this issue.

Recommendation 18:

Arrangements should be put in place to ensure leadership on this issue across the system – from Ministers and the Department of Health and system leaders, through to SHAs, PCTs and NHS Trust boards. Boards should nominate a senior member to ensure that effective services for victims are put in place in line with this report.

Regulation

6.17 Regulators have a critical role to play in ensuring that services meet common standards and in challenging organisations to improve their services. They have a range of enforcement powers to support them in delivering their role including, in the case of the Care Quality Commission (CQC) which regulates health and adult social care services, the power to cancel the registration of a provider organisation that fails to meet the Commission’s essential standards of quality and safety as set out in legislation. Regulators also have

a responsibility to promote the rights of people using services, which clearly includes vulnerable people such as those who have experienced or are experiencing violence or abuse. We would like to see in the guidance material issued by the regulators a clear recognition of the importance of ensuring that commissioned services are responsive to the needs (and not just the healthcare needs) and wishes of women and children with experience of violence or abuse.

- 6.18 In addition to the responsibility for registering health and adult social care provider organisations, and assessing the performance of commissioners and the outcomes they produce for their populations, the CQC also has the power to undertake ‘special reviews’ of particular service areas or themes. We believe that there would be a great deal to be gained from undertaking such a review in relation to the NHS response to violence and abuse of women and children once the initial Government response to this report has been implemented.

Recommendation 19:

Regulators of health and social care services (in particular the Care Quality Commission (CQC)) should embed the issue of violence against women and children in their work programme, including registration. The CQC should consider undertaking a special review of how well the NHS deals with the issues highlighted in this report after implementation of the initial Government response.

- 6.19 We strongly support the Government commitment to establishing one SARC in each police force area by 2011 and hold Government to this commitment. However, it is not clear where the responsibility for regulating SARCs lies. This in part reflects the multi-agency nature of the work undertaken by the centres. It is important that these centres, which do such vital work with vulnerable women and children, are properly regulated and that those who work in them are clear about the

regulatory framework. The recent publication by the Department of Health, the Home Office and the Association of Chief Police Officers of the *Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres* (2009) provides a helpful set of minimum elements for SARCs. Standards for children include the RCPCH *Service Specification for the Clinical Evaluation of Children and Young People who may have been sexually abused* (2009), the *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills, 2004) and the *You're Welcome quality criteria: Making health services young people friendly* (Department of Health, 2007). It is clearly important that the NHS takes responsibility for commissioning SARCs, working in partnership with other agencies such as the police force.

Good practice example – The Bridge

A SARC serving four unitary authorities (Bristol, South Gloucestershire, Bath and North East Somerset, and North Somerset) and Somerset has been constructed in Bristol as part of the Acute Hospital Trust redevelopment of its Sexual Health Services at the Central Health Clinic, Tower Hill in Bristol.

The model for this area is a joint partnership between the police, health, CDRPs and the voluntary sector.

Governance

A governance board exists, chaired alternately by the police and health and enjoying wide representation from stakeholders, both statutory and non-statutory.

A partnership agreement has been agreed and there is considerable commitment, including long-term financial commitment, to the centre despite the complications of multi-agency working.

Funding

Costs are split equally between Avon and Somerset Police and the PCTs covering the area.

The PCTs have agreed an initial split of their contribution (in year one) based on population as opposed to volume of service users. This will be reviewed for year two. Bristol PCT has agreed to take the role of lead PCT with responsibility for communicating to and from the board on PCT issues.

An Independent Sexual Violence Advisor post is funded and commissioned locally by the CDRPs. Safer Bristol CDRP has agreed to take the role of lead CDRP. Due to the nature of CDRP funding, this post is time-limited, with funding due to expire in April 2010.

Two further Home Office grants have been secured for the employment of a second Independent Sexual Violence Advisor and a Child and Young Persons Sexual Violence Advisor. Funding for these posts is time-limited for 12 months.

Recommendation 20:

The Government should ensure that clear processes for clinical governance, supervision and regulation are put in place for Sexual Assault Referral Centres (SARCs), and these should be effectively communicated to those managing and working in SARCs and the National Support Team on the Response to Sexual Violence.

provision does not meet these requirements. In particular, the Faculty should set quality standards in this area.

“They [health professionals] need training to understand us and how not to make us feel dirty.”

Recommendation 21:

The Department of Health should work with the relevant regulators and professional bodies to ensure that clinical staff undertaking forensic medical care are:

- appropriately trained, skilled and experienced;
- employed by the NHS;
- integrated into NHS clinical governance;

6.20 The provision of high standards of forensic medical care across the whole criminal justice system, including SARCs, is essential. Recent developments, including qualifications in clinical forensic medicine and the work being undertaken by the Faculty of Forensic and Legal Medicine and the Royal Colleges, will support improved quality of care.³² It is vital that forensic physicians provide care of the highest quality and are properly integrated into the clinical governance framework of the NHS. There are indications that current

³² Recent qualifications include: the Diploma in Forensic and Clinical Aspects of Sexual Assault; and Membership of the Faculty of Forensic and Legal Medicine.

- working within a quality standards framework agreed by the Forensic Science Regulator and the Faculty of Forensic and Legal Medicine; and
- commissioned in sufficient numbers to meet the needs of women and children.

7: Conclusion

“We need the Department of Health to listen to us and learn from our experiences, to put our recommendations into practice, otherwise what’s the point of asking us our views in the first place? All this consultation costs money. We now need to stop talking about it and start improving the health system’s response to violence against women. We need action, not words.”

- 7.1 The NHS has a vital role to play in dealing with violence and abuse and its consequences, both short- and long-term. The human cost of violence and abuse is beyond reckoning, and the call from women to move from words to action is beyond dispute. The NHS has a clear duty to help and, as far as possible, heal the victims of violence and contribute to multi-agency efforts to increase the safety of women and children in our society.
- 7.2 As we move into a period of relative financial constraint in the NHS, the temptation for some organisations will be to draw a distinction between ‘core’ services and more ‘marginal’ activity; and for some, work to address the causes and consequences of violence in partnership with

other agencies might look like something that could be stopped with relative ease. This would be entirely misguided. The new financial context makes it more important than ever to focus on the preventative measures that keep adults and children well and safe and on making the most of public resources by working in partnership with other agencies. It is encouraging that these principles have been endorsed so clearly in the recently published NHS Operating Framework for England for 2010/11.³³ We are convinced that the application of these principles to violence and abuse against women and children will lead both to improvements in health and well-being and, over

³³ See www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107, pp.14 and 47–8.

time, to savings for the public purse.

- 7.3 All of us who play a part in the NHS – from frontline staff to those with responsibility for commissioning and setting the strategic direction of the system – have a responsibility for making change happen now. This requires some oversight (as set out in our final recommendation below) but above all else it requires action today and tomorrow: sustained, evidence-based action. The absence of high-quality evidence in some of the areas covered in this report reflects both the relative priority this has commanded in research programmes and the difficulty in carrying out high-quality trials and producing evidence-based guidelines. We hope that this can be addressed and that, in addressing our recommendations, the Government will commission further research and encourage the development of clinical guidelines to fill the current gaps.

- 7.4 It is for the Government now to respond to this report, and it must provide a lead on this issue. But none of us who work in the NHS need a government report to start improving services for women and children right now – and that is what we should be doing.

Recommendation 22:

A national steering group should be established to oversee implementation of this taskforce's recommendations.

Recommendation 23:

The Government should review the evidence base with a view to identifying and addressing significant gaps in the evidence base.

Annex 1:

Terms of reference for the taskforce

Taskforce summary

To identify the role and the response of health services in preventing, identifying and supporting women and girls who are victims of violence and abuse, and to make recommendations on what more could be done to meet their needs.

The taskforce will work to:

- estimate the prevalence and cost to the NHS of all forms of violence against women and girls;
- review the evidence on the health care needs of women and girls who are or have been victims [of] violence or abuse, and to assess the extent to which their needs are currently met by the NHS;
- review the role of NHS in local strategies for reducing violence against women and girls – including participation in Multi Agency Risk Assessment Centres, Crime and Disorder Reduction Partnerships, children’s trusts arrangements; and the potential for improving data sharing with other local agencies; and
- establish the case for earlier interventions to prevent violence against women and girls and beneficial impacts on health and other public services.

And we expect the taskforce to make recommendations on:

- improving the early identification of women and girls who are victims of violence and abuse;
- improving the quality of, and access to, services for women and girls who are victims of violence or abuse;
- raising the profile of violence against women and girls amongst NHS frontline staff and commissioners as well as their partner agencies;
- staff training and development; and
- embedding improvements in the NHS by making the most effective use of existing NHS resources.

Role of the Taskforce sub-groups

The Taskforce will establish four sub-groups to look at:

- Domestic Violence
- Sexual Violence against Women
- Sexual Violence against Children
- Harmful Traditional Practices and Human Trafficking

The role of the sub-groups will be to consider the available evidence and draw together proposals for submission to the Taskforce steering group under the categories above within their workstrand.

Taskforce sub-group outputs

Each sub-group will be required to write a report setting out their proposals in relation to their workstrand, including an evidence-based rationale. The proposals will be for consideration by the Taskforce Steering Group and will help inform the Taskforce recommendations.

It is expected that the proposals will be realistic and based on the capacity and capability of the system to deliver change and improvement, and will be within the current NHS funding envelope.

Annex 2:

Membership of taskforce steering group

Oonagh Aitken	National Adviser, Children and Young People, Local Government Association Group
Professor Sir George Alberti (Chair)	Clinical Advisor to NHS London, Senior Research Investigator at Imperial College London and Emeritus Professor of Medicine at Newcastle University
Obi Amadi	Lead Professional Officer, Unite (the Union) – Health Sector (incorporating Community Practitioners’ and Health Visitors’ Association)
Louis Appleby*	Co-chair, Sexual Violence Against Women sub-group, National Director for Mental Health in England and Professor of Psychiatry at the University of Manchester
Dr Susan Bewley	Consultant Obstetrician/Maternal Fetal Medicine, Guy’s & St Thomas’ NHS Foundation Trust
Dinesh Bhugra	President, Royal College of Psychiatrists
Dame Carol Black	National Director for Health and Work
Eleri Butler	Violence Against Women Policy Manager, Women’s National Commission
Miss Sarah Creighton*	Co-chair, Harmful Traditional Practices and Trafficking sub-group, Consultant Gynaecologist, University College London Hospital
Moira Dumma	Chief Executive, NHS South Birmingham
Mike Farrar/ Deputy Dr Ann Hoskins	Chief Executive, NHS North West/ Director of Children, Young People and Maternity, NHS North West
Gene Feder*	Co-chair, Domestic Violence sub-group, Professor of Primary Health Care, University of Bristol
Dr Clare Gerada	Vice Chair of Council, Royal College of General Practitioners

* Sub-group co-chairs

Ruth Hussey/ Sarah Lewis	Regional Director of Public Health and Medical Director, NHS North West/Regional Strategic Health Manager for Crime and Disorder, NHS North West
Ann Jackson	Learning and Development Facilitator, Royal College of Nursing
Shirlene Jones	Head of Nursing, Emergency and Urgent Care Centre, Whipps Cross University Hospital
Christopher Long*	Co-chair, Domestic Violence sub-group, Chief Executive, Hull Teaching PCT
Vince McCabe	Managing Director, West Essex Community Health Services
Astrid Osbourne	Head of Midwifery and Supervisor of Midwives [interim], Queen Mary's South London Healthcare NHS Trust; Consultant Midwife, University College London Hospital
Dr Rosalyn Proops*	Co-chair, Sexual Violence Against Children sub-group, Child Protection Officer, Royal College of Paediatrics and Child Health
Dawn Rees*	Co-chair, Sexual Violence Against Children sub-group, National CAMHS (Child and Adolescent Mental Health Service) Strategic Relationships and Programme Manager
Dr Karen Rogstad*	Co-chair, Sexual Violence Against Women sub-group, Royal College of Physicians, London, Consultant Physician in GU Medicine, Sheffield Teaching Hospitals NHS Foundation Trust
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