Piloting Routine Enquiry in Leeds GP Practices

Learning from Moorfield House Surgery, Garforth

(October 2015 - September 2016)

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November 2016
Introduction

Tackling domestic violence and abuse is a key priority for Leeds. Leeds City Council (LCC) has identified domestic violence and abuse as one of its eight breakthrough projects. The breakthrough projects are designed to identify new ways of working within the council and with partners to achieve the best outcomes for the city. Through the breakthrough project, LCC hope to significantly increase public knowledge and awareness of what constitutes domestic violence and where help is available.

This report is written by the Safer Leeds Domestic Violence Team and aims to present learning and findings from one strand of the Domestic Violence Breakthrough Project which focused primarily on piloting routine enquiry within GP practices. The pilot has been a joint venture between Safer Leeds and the Clinical Commissioning Group’s (CCGs) Safeguarding Team, working together to identify receptive GPs to undertake the pilot. Work is ongoing to evaluate the effectiveness of routine enquiry in GP settings.

Since April 2011 there have been 17 domestic violence related deaths in Leeds including five children who were killed alongside their mothers. Lessons learned from Domestic Homicide Reviews, both on a local and national level have often revealed that victims of domestic homicide have had some contact with their GP in the lead up to their death. In a recent report for Standing Together one of the key findings in relation to GPs was that “the information held by GPs is often invaluable, it helps ‘fill the gaps’, especially when a victim and/or perpetrator has not had contact with any other statutory body”. (Domestic Homicide Review, Case Analysis 2016)

It is widely acknowledged that asking individuals about their experiences of domestic violence and abuse is more likely to encourage disclosures, therefore we decided to promote and trial routine enquiry amongst GPs in Leeds. GPs can play an important role in identifying victims of domestic abuse, particularly where victims are reluctant or unwilling to disclose to other professionals. Equipping GPs with the knowledge to identify domestic abuse victims, risk indicators and referral pathways can mean earlier interventions for victims and their families.

Eighty percent of women in violent relationships seek help from health services, usually their GP (DOH, 2000). This can often be their first and only contact with professionals.
The financial cost of DV/A to the health service is £1.7 billion per year with the major costs involving GPs and hospitals. This does not include the cost to mental health services, estimated at an additional £176 million. (Walby, S 2009) The human costs of domestic violence and abuse are immeasurable. By empowering GPs in their ability to identify DV early, we envisage economic savings will be achieved through more timely interventions as well as going some way in helping tackle the human costs of experiencing ongoing abuse.

GPs and Routine Enquiry

“ Violence against women is not a new phenomenon, nor are its consequences to women's physical, mental and reproductive health. What is new is the growing recognition that acts of violence against women are not isolated events but rather form a pattern of behaviour that violates the rights of women and girls, limits their participation in society, and damages their health and well-being” (World Health Organisation, 2013).

The gendered nature of domestic violence and abuse is well recognised, particularly in relation to serious harm and homicide* and for that reason we chose to focus the pilot on women only at this point. We acknowledge that men can also be victims of domestic violence and abuse and that more understanding and research is required to establish whether routine enquiry with male victims would be beneficial.

“ It has been found that routinely asking women about domestic violence is more appropriate than ‘ad hoc’ enquiry that may rely on stereotypical views around which groups of women are likely to experience domestic violence. Routinely asking gives the message that it is acceptable to disclose domestic violence and that no-one is being specifically targeted for enquiry (which could have safety implications)” (Hester and Pearson, 1998).

Routine Enquiry is simply finding a way of asking female patients directly and confidently about Domestic Violence and Abuse. (DV/A)

In response to specific health recommendations from the NICE PH50 Guidance (Feb 2014); findings from the Leeds Scrutiny Report (2014); Domestic Homicide Reviews Lessons Learned and evidence from Identification and Referral to Improve Safety (IRIS)* model, we decided to explore ways in which health professionals in primary care can increase disclosures of domestic violence and abuse through routine enquiry with female patients and offer earlier help.

The approach taken built on the learning from the IRIS model, and encouraged GPs to specifically ask all female patients about domestic violence and abuse. That is, to promote “routine enquiry”, expanding on the IRIS approach of a “triggered enquiry” – where the question is asked in response to a suspicion that abuse may be present.
The latter largely depends on the individual GP’s knowledge and awareness of DV/A and often a reliance on visible injuries. Many victims present without any obvious physical injuries, and therefore routine enquiry provides an opportunity to all women seen alone, regardless of presentation, to disclose domestic abuse.

Four practices agreed to pilot routine enquiry and all began their pilots at different stages. This report focuses on the learning so far from one practice. Further work will be undertaken to draw out findings from other practices.

**Pilot requirements**

To promote consistency in approach, the elements listed below were identified as necessary to any practice undertaking routine enquiry:

- Implement routine enquiry for all female patients aged 16+ presenting alone.
- Nursing staff to routinely ask all female patients attending the surgery for a smear and presenting alone.
- Flag DV/A on electronic systems and confirm question asked and action taken. Clear recording of disclosure, risk indicators and agreed follow up.
- Identify DV/A Champion for the surgery to support referrals to DV services or specialist DV/A worker if funding is available.
- All staff receive training from the DV team.
- Access to a private room for victims to make safe contact with services.
- Provide relevant data to the Safer Leeds Analytical Team to monitor and evaluate outcomes.

**Resources**

The Safer Leeds Domestic Violence Team worked alongside a media company and staff from Leeds General Infirmary and Moorfield House Surgery to produce *Ask, Acknowledge, Action* (a short film on “asking the question” and responding appropriately to victims of DV/A). The film was completed in January 2016 and is now used in GP training and training for health practitioners across Leeds. The aim of this resource is to increase understanding of routine enquiry among health staff. The film can be reviewed at: [https://youtu.be/UvZZNZIbboQ](https://youtu.be/UvZZNZIbboQ)
Domestic Violence and Abuse
Awareness training sessions were delivered to practice staff before beginning routinely enquiring.

Leeds Women’s Aid secured funding for 12 months: this allowed them to offer specialist support for both patients and staff, at each pilot practice for one morning or afternoon per week.

Posters and leaflets were provided and displayed in each practice.

Ongoing support and advice was available via the Safer Leeds Domestic Violence Team.

Course Content

What is Domestic Violence and Abuse (including coercive control)

Why do women stay/go back?

Additional barriers to leaving or disclosing DV/A by women from marginalised groups; women with mental health issues; drug and alcohol dependencies and women with disabilities.

Learning from Domestic Homicide Reviews and Lessons Learned

How to ask the question and respond appropriately

Flagging and recording information

High Risk and DASH, Multi Agency Risk Assessment Conference (MARAC) process

Help available and referral pathways

Recording Systems

A Domestic Abuse template for SystemOne and EMIS was developed by the CCG with support from the Safer Leeds Team. The new template allows the GP to record that they have asked the question, the patient’s response and any action taken; it also includes a DV/A flag to alert GPs and other health practitioners accessing the system. GPs can also access local and national numbers and referral information about high risk cases and MARAC (Multi Agency Risk Assessment Conference) via links on the template.
Pilot Process

- The idea was introduced at the GP Target Training in May 2015; GPs from all three Clinical Commissioning Groups (CCG) in Leeds attend.

- We asked GPs to complete an evaluation form to identify if they were interested in taking part.

- A number of GP practices involved in local Domestic Homicide Reviews were directly contacted.

- York Street Practice was also approached directly due to its diverse and transient client group.

- This was followed by a meeting with the GPs to explain the pilot process and address enquiries and concerns.

- Four GP Practices agreed to be part of the pilot.

- Attempts to include practices from each CCG proved difficult. (Due to uneven spread of GPs in a position to engage at the time or slow communication due to practice time pressures).
Moorfield House Surgery, Garforth.

Moorfield House Surgery is one of four GP practices in Leeds involved in the routine enquiry pilot and the first to complete the pilot. This required GPs, Practice Nurses and Health Care Assistants to ask all unaccompanied female patients, attending appointments, aged sixteen and over, whether they are experiencing domestic violence and abuse. We have anecdotal evidence from patients and a GP’s perspective in this report on routine enquiry along with a case study. We have provided statistical information in an attempt to exemplify the effectiveness of routine enquiry in helping GP practices to identify and respond to domestic violence and abuse.

Garforth has a population of 24,000 and in the last ten years has experienced two domestic homicides. Given this statistic, the GPs at Moorfield House Surgery and the Practice Manager were keen to take part in the pilot. The surgery is a relatively small practice with three GPs and for a short period of time during the pilot they employed a locum GP. This team was made up of 3 female GPs and 1 male GP. The practice has around 4,500 patients and uses the EMIS system for patient records. All the staff team received training in early October 2015, with a further training session on MARAC and Risk Assessment completed in January 2016. GPs and practice staff began the Routine Enquiry pilot at the end of October 2015.

Leeds Women’s Aid secured 12 months funding for a specialist DV/A worker who provides weekly support*. The GPs and practice staff were able to book appointments for patients wanting to see the specialist worker and she had restricted access to the EMIS system to update patients’ records. The funding for this post ceased in October 2016. With this in mind, we asked that practices identify an in-house DV Champion – the Champions at Moorfield House Surgery are a GP and the Practice Manager.

* for any woman disclosing DV and A and willing to take up the offer of support
The EMIS system did not allow us to identify single and repeat presentations at the start of the pilot therefore we are unable to ascertain the actual number of women attending during this time frame.

**THE IMPACT SO FAR**

✓ **1642 consultations** with female patients between October 2015 & September 2016 (some women presented more than once)
✓ **390 women** were asked the question (at the start of the pilot fewer women were asked – see Challenges - the number increased as the pilot went on). There were:
  
  ➢ **12 new disclosures (+ 4 already known)**
  ➢ **54 disclosures of historic abuse**
✓ The DV worker completed **30 support sessions (Data up to July 2016)**

![Diagram showing impact]

- **OCTOBER 2015**
  - **SEPTEMBER 2016**
  - **390 WOMEN ASKED**
  - **16 CURRENT VICTIMS – 12 NEW DISCLOSURES**
  - **54 HISTORY OF ABUSE – ALL NEW DISCLOSURES**
  - **70 DISCLOSURES IN TOTAL = 18% of the women asked**

[http://www.lwa.org.uk/understanding-abuse/statistics.htm]
HCAs = Health Care Assistants

**Challenges**

A number of factors were identified and addressed during the pilot period that the GPs believe led to an increase in disclosures as time went on:

The GPs asked fewer women at the start of the pilot due to:

- Lack of confidence in the GPs ability to respond appropriately.
- A fear that patients would be offended.
- A propensity to stereotype patients in terms of status, profession, age etc. initially deterred GPs from asking some patients the question.
- Concerns that the length of consultations would be affected.

- The male GP initially felt less confident than his colleagues about asking his patients and described his attempts as “random”.
- The electronic recording system was not fully operational; the prompt for asking the question wasn’t available from the start of the pilot.
- It proved particularly difficult to routinely enquire during holiday periods due to women being accompanied by children.
- The GP was unable to ask due to some women being accompanied by their partners or family members.
Patient questionnaire feedback:

Six women from the surgery consented to in depth interviews (15 minutes plus) and were interviewed by telephone. All six women thought routine enquiry was a good idea and none were offended by being asked the question

*Example Question: Do you think that all GPs should ask female patients about domestic violence and abuse – if it is safe to do so?*

“*Yes I do. And they should ask regularly. I thought domestic abuse was black eyes and broken bones. But he was very clever. The signs were not obvious. But all the time he was in control.*”

“*Yes, if it was put in the right way. As I know it goes on a lot. You see it in the press and on TV and don’t talk about it. It’s a good thing.*”

GP Feedback

“This work has really increased my awareness of domestic violence and confidence in asking the question and dealing with disclosure. We have picked up a surprisingly large number of historical abuse victims too. We found that all patients wanted to talk and some were still carrying issues from past abuse that was affecting their current physical and mental health.”

Support Worker Feedback

“I believe that it did make a difference especially in the surgeries who were completely on-board with the pilot. Hopefully the pilot has given GPs more of an understanding of the issues women face around domestic abuse and seeking support and an awareness of the signs. GPs will hopefully feel more comfortable talking about the subject now they have more of an understanding of services available and how to refer.”
Case Study

**Patient** - 37 year old single mum

**Presented with** - episodes of diarrhoea for several months, tiredness, palpitations, chest tightness and pain and trouble sleeping. She came in because she googled her symptoms and the computer said ‘you may be depressed and need to see your Doctor.’

**On routine enquiry** – she became very upset. Her ex-partner had been violent and recently he had been contacting her a lot. The GP decided to do some blood tests and she agreed to a referral to the DV support worker.

**Follow up** - she saw the DV support worker who carried out an initial assessment and risk assessment, discussed services that may be able to help her.

She told the GP ‘I found it very helpful talking to Debbie’ *(the DV support worker)*

In this case, the GP felt that by enquiring about domestic abuse routinely, the “root” of the problem was identified at an early stage – her abusive ex-partner re-establishing contact with her had a significant impact on her current health. Assessments were carried out in a timely manner enabling the patient to explore and discuss a safety and support plan with the DV support worker.

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**Feedback from patients not affected by DV**

“I am really pleased you’re asking the question”

CB, age 60

“I think this is a good starting point and am really pleased you are asking this….Maybe women will go away and think about it & feel safer to come back and talk to you”

WL, age 53
Key Learning and Findings:

- None of the patients at Moorfield House Surgery were offended by being routinely asked about DV and A.
- Whilst initially uncomfortable with asking the question and dealing with disclosure, all the GPs and nursing staff became more confident as time went on.
- There was no significant impact on the GPs’ time.
- There were 12 new disclosures of current DV/A and 54 new disclosures of historic abuse, of which, some was still affecting current physical and mental health.
- GPs discovered that women of all ages, professions and backgrounds disclosed abuse and that there was no one particular “type”.
- The DV/A training improved the GPs’ knowledge and understanding of the issue and how this impacts on health.
- The specialist worker completed 30 support sessions with 16 women.
- There were particular times when there was a reduction in number of patients asked e.g. school holidays.
- Whilst still in the early stages, the electronic flagging system on SystmOne and EMIS can save GP time, alerting them that domestic abuse is present with an on screen flag.
- The pilot has been well received and is supported by the practices Patient Reference Group.

“With us (Moorfield House) having the Safer Leeds Quality Mark and asking the question, patients are becoming aware that we are a ‘domestic violence & abuse friendly’ practice and will hopefully have the confidence to disclose when ready.”
Dr Sultan
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12 months on and all staff at Moorfield House Surgery are asking – they have committed to continue with routine enquiry.
Conclusions:

- Routine Enquiry does encourage disclosure of both current and historic abuse.
- Routine Enquiry is manageable for GPs with the right support, training and recording systems in place.
- GPs need a clear and robust referral pathway – ideally to a designated worker or, if not, to existing services.
- Patients can be offered earlier help.
- Domestic violence and abuse, whether current or historic, can and does have an impact on a person’s health and well-being.
- Moorfield House Surgery was awarded the Safer Leeds Domestic Violence and Abuse Quality Mark, Level 1, in March 2016.

Next Steps:

- An update on the pilot was presented at the GPs’ Target session in May 2016. A further 30 practices have expressed an interest in implementing routine enquiry.
- The Target session for nurse practitioners in September 2016 generated interest and 15 practices have requested training on routine enquiry.
- The Safer Leeds Domestic Violence Team are working with safeguarding leads in the CCG to explore how the model can be rolled out across Leeds.
- NHS England North region are keen to look at how the model can be shared and introduced in GP Practices across the North of England.
- The DV team and the CCG are working in partnership to provide Level 3 (PH50 Nice Guidance) DV/A training for GPs.
- All practices in Leeds will adopt the DV/A template, improving flagging and recording domestic abuse on patient records.
- The report will be presented to the Health and Domestic Violence and Abuse Strategic Delivery Group members for comments and approval.

Useful Links:

www.leedsdomesticviolenceandabuse.co.uk

http://www.irisdomesticviolence.org.uk/iris/  *

https://www.nice.org.uk/guidance/ph50

http://www.safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse  *

www.leeds.gov.uk/saferleeds