NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Domestic violence and abuse

Date of Quality Standards Advisory Committee post-consultation meeting:
03 November 2015

2 Introduction

The draft quality standard for Domestic violence and abuse was made available on the NICE website for a 4-week public consultation period between 16 June and 14 July 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 52 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1 and 2: Do these services reflect those who would mainly encounter people with possible indicators of domestic violence or abuse? If not what other services should be included?

5. For draft quality statement 1 and 2: Are there specific ‘at risk’ groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?

6. For draft quality statement 1 and 2: Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?

7. For draft quality statement 1 and 2: How should 'private' be defined within each setting?

8. For draft quality statement 3: What should an 'assessment of immediate safety' involve?

Stakeholders were also invited to respond to the following question about potential additional quality statements:

9. The Quality Standards Advisory Committee recognised that multi-agency partnership working and an integrated strategy are important approaches for managing domestic violence and abuse.

What specific actions should be undertaken by this multi-agency partnership or outlined in integrated strategies to improve quality in this service?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Overall the proposed statements were considered to reflect areas for quality improvement and help establish enquiries into DVA as part of routine practice, instigating needed cultural change within health and social care.
- Budgetary constraints and the need for extra resources to be made available.
- Lack of knowledge and awareness across health and social care in general on what people are entitled to and what help can be provided e.g. people with limited resources, asylum seekers and migrants.

- The need for mandatory and on-going training and education across all sectors in this area training for all health care staff is essential[1] and the use of a single set of recognised standards and curricula should be employed.

- The need for guidance on how health and care organisations engage with one another in dealing with DVA.

- Encouraging the Care Quality Commissions (CQC) to use its leverage to promote implementation.

- The need to include reference to groups often under represented including children, men, LGBT, older people, carers and those with care and support.

- The need to include reference to other key professionals and organisations e.g. forensic specialists, youth offending teams and sexual assault referral centres (SARCs), safeguarding children boards (LSCB) and adult safeguarding boards (ASB).

- The need to reflect the duties of local authorities under the 2014 Care Act. This identifies safeguarding adults at risk of abuse or neglect as an explicit requirement including establishing local safeguarding adult boards. This will necessitate a multi-agency approach.

- The need to frame within a social care context and emphasise safeguarding those with care and support needs referencing relevant guides[2].

- The need to consider how this will fit with other types of abuse such as female genital mutilation (FGM), child abuse and sexual grooming of children.

Consultation comments on data collection

- Consistent data recording across healthcare is essential for multi-agency working.

[1] Against Violence and Abuse (AVA) outline within the consultation that they have been commissioned by Public Health England to develop e-learning modules to support the training outlined in the NICE guidance.
[2] For example Adult safeguarding and domestic abuse - A guide to support practitioners and managers (2015).

- Some stakeholders considered data collection problematic and noted that most health and social care organisations have different IT systems.
- Some stakeholders felt it will be possible to collect data for the proposed quality statements with appropriate systems, structures and guidance.
- There will be a need for national standards and standardised templates and for systems to link and have effective data sharing mechanisms for multi-agency working to be effective.
- Issues around confidentiality and sharing information e.g. GP data, and concerns that multi-agency data sharing can act as a disincentive to disclosing DVA e.g. anecdotes that pregnant women where the fear and implications of involving social services can have implications.
- Currently availability and reporting of data varies.
- Concerns around funding pressures and the need to develop IT systems.
- There needs to be emphasis on safely recording information on DVA.
- Multi-agency working and a central hub would help.
- The Electronic Patient Record (EPR) system will be key in monitoring compliance to the standards.
- Approved READ codes would help with consistent data capture.
- Concerns around capturing data where opportune enquiry is undertaken.
- Concerns around capturing data where this may be seen as a task of low priority e.g. in A&E departments.
- Data is likely to be easier to collect in maternity services than in A&E.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1 and 2

People presenting to A&E departments with indicators of possible domestic violence or abuse have a private one-to-one discussion.

Women presenting to maternity services with indicators of possible domestic violence or abuse have a private one-to-one discussion.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1 and 2:

- The need to specifically ‘ask the question’ about DVA and make an ‘enquiry’ into DVA instead of having a ‘discussion’.
- Outline specifically who ‘people’ are e.g. people with a disabilities, women in same sex relationships etc.
- Consider including the word “confidential”.
- Concerns that at current many health professionals are unsure how to intervene and what to do with disclosures.
- The need for training so health professionals know how to identify the indicators of possible abuse, make enquires and record information about DVA.
- Concerns that the first contact is unlikely to elicit information as disclosure is often based on trust.
- Comments that it is often difficult to assess if people are presenting with indicators of DVA and thus routine enquiry should be standard care.
- Acknowledgement that healthcare staff experience DVA too and how to address this.

- The need for dedicated space for private discussions to take place.
- The need for co-location of Independent Domestic Violence Advocates (IDVAs) within hospitals/healthcare settings.
- The need to be explicit about the safety of people who disclose experiencing DVA.
- Concerns around damaging the clinician/patient relationship with false suspicion and what the threshold for suspicion should be before questioning
- The need to consider safety of healthcare professionals especially where perpetrator is likely to be present.
- The need for specialist DVA practitioners or workers within both settings.

Consultation question 4

Stakeholders made the following comments in relation to consultation question 4 which asked if the services listed (A&E and maternity) reflected those who would mainly encounter people with indicators of DVA:

- Some stakeholders considered A&E and maternity services adequately reflect services that would mainly encounter people with possible indicators of DVA.
- A suggestion that maternity services are well covered and may not need additional specific focus which could be better used elsewhere.
- Others considered different services more relevant and in particular GPs and mental health and substance misuse services were suggested.
- General feeling of the need to cover all health providers to ensure people experiencing or perpetrating DVA are considered across all health services.
- The full range of settings considered to encounter people with possible indicators of DVA included:
    - Primary care/GPs

  - Community health services including, district nursing, health visiting and long term condition teams
  - Nurseries/schools
  - Mental health services
  - Sexual and Reproductive Health Services
  - Substance misuse services
  - Other urgent and unplanned care services such as walk-in centres, emergency eye and dental care services
  - Custody settings
- Concerns were expressed that only concentrating on certain services may have unintended consequences e.g. continuing stereotypes that DVA only affects women, dis-incentivising the provision of support in other areas and disadvantaging groups more likely to present elsewhere e.g. perpetrators.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5 which asked if there are specific 'at risk' groups who should be asked about DVA:

- Stakeholders noted difficulties in creating an exhaustive list and highlighted concerns that outlining specific groups may create stereotyping and gaps in provision.

- A universal screening approach would capture more people and reduce professional bias and under-recognition whilst giving staff permission to talk about DVA and avoid people feeling stereotyped.

- Stakeholders noted that not including people without any indicators of DVA may miss groups and we should promote routine and opportunistic enquiry.

- Other stakeholders noted that generally speaking women are at highest risk and routine enquiry should be mandatory for these particularly pregnant women.

- Suggestions to escalate risk where there is evidence of DVA alongside mental health issues and substance misuse.

- A comment that babies and young children cannot be ‘asked’ about or disclose DVA.

- Other specific at risk groups suggested for inclusion were:

  - Young people aged 16-25
  - LGBT
  - Sex workers
  - Trafficked persons
  - Substance misuse populations
  - Individuals with language barriers
  - Homeless populations
  - Migrants/refugee status
  - History of social care involvement
  - Learning difficulties or disability
  - Mental health issues
  - Financial dependence
  - Poverty
  - Minority ethnic women
  - Carers
  - Women with antenatal or postnatal depression

- Other indicators of DVA suggested for inclusion in the long list provided in the definitions of the QS were:

  - Missed appointments and non-compliance with treatment
  - Denial or minimisation of abuse/injuries
  - Injuries which do not fit the explanation of the cause
  - Multiple injuries at different stages of healing
  - Delay between an injury occurring and seeking medical treatment
  - Repeated, non-specific symptoms
  - Appearing evasive, socially withdrawn and hesitant
  - Multiple visits to GP's for non-specific issues

  - Unexplained injuries

- Stakeholders noted the ‘SPECSS’ indicators used by the Metropolitan Police; separation, pregnancy, escalation, community isolation/children, stalking, sexual violence and the person’s own fear.

- Stakeholders emphasised the need for greater education about risk factors and suggested that the main issue is whether services understand the specific needs of different groups and can respond to them appropriately.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6 which asked if a discussion would always take place on a one-to-one basis:

- Some stakeholders considered a one-to-one discussion as part of routine practice at every contact essential in order to achieve quality outcomes.

- Other stakeholders noted that in practice perpetrators are unlikely to let victims be seen alone and staff must know how to recognise these situations and respond accordingly. Rejection of private discussions may indicate DVA and innovative methods should be employed to facilitate disclosures without increasing risk.

- Private one-to-one discussions may be possible in some settings and situations e.g. (inpatient or outpatient/clinics and A&E) but not others (e.g. in service users homes or where the person lacks capacity).

- Some considered more than one staff or trusted person may be appropriate and should be a matter for professional judgement e.g. where people require additional support (language translation or independent advocates). It was noted these should be sourced from professional services and not family, friends or carers.

- A chaperone or someone of the same sex, gender should be offered.

- Overall it was acknowledged that this is a difficult area requiring good the ability to manage situations on a case by case basis.

- Concerns around how to manage this situation and ensuring perpetrators do not discover through professional carelessness, disclosures.

- Managing divergent policies e.g. around involve expectant fathers more in care.

Consultation question 7

Stakeholders made the following comments in relation to consultation question 7 which asked how ‘private’ should be defined:

- A separate room with walls and a door, without disruptions and not being able to be oversee or overheard but with access to phone/language lines as necessary.

- Cue cards were suggested in situations where this is not possible e.g. curtained cubicles.

- Stakeholders noted that by exposing that people are seeking help can significantly increase risk and suggested consideration be given to other innovative ways where necessary e.g. using stickers or other types of alert. Providing information in toilets was suggested to be a useful tool to help facilitate disclosure.

5.2 Draft statement 3

People who disclose domestic violence or abuse have an assessment of their immediate safety.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Outline specifically who ‘people’ are e.g. people with a disabilities, women in same sex relationships etc.

- Stakeholders noted research identifying an increased risk of serious harm at the time of 'leaving' and importance of dealing with this issue correctly.

- Whist health professionals can offer some practical and emotional support this requires training and more specialist DVA practitioners and services.
- Risk assessment should engage multiagency partners and safeguarding.
- Multi-Agency Risk Assessment Conference (MARAC) is an important source of safety planning and there could be plans already in place in high-risk situations.
- Concerns that check lists can result in false positives and false negatives and a given risk is dynamic a more investigative approach is required.
- The need for minimum standards to outline what should happen following identification of immediate risk and for these to be embedded into policies.

Consultation question 8

Stakeholders made the following comments in relation to consultation question 8 which asked what an 'assessment of immediate safety' should involve:

- Some stakeholders welcomed the focus on an assessment of safety rather than risk whist others felt this term may be misleading since the issue is around risk and the immediacy of DVA when victims leave contact with care services.
- Use of a simple, relatively quick and straight forward nationally approved and developed risk assessment tool.
- Some stakeholders suggested using the Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Assessment Checklist (RIC) whilst others felt this tool was inappropriate due to its length.
- The Identification and Referral to Improve Safety (IRIS) model for primary care was also suggested which requires more simple questioning about i) the immediate safety of patients to return home and ii) the safety of children in the home.
- Concerns that current tools do not adequately cover the needs of children and young people.

- Other tools such as the BASHH & Brook child sexual exploitation (CSE) proforma - *Spotting the Signs*, or the Edinburgh Post Natal Depression (EPND) scale.

- Other suggestions around what an assessment of immediate safety/risk assessment should involve included:

    - Listening and asking what support people would like
    - Asking who the perpetrator is, when the last episode happened and what happened during the worst episode.
    - Identifying if the perpetrator is free to continue to commit DVA and risk assessing the likelihood of this occurring.
    - Identifying potential harmful weapons.
    - Identifying rationales/triggers for DVA e.g. debt or relying on the perpetrator for drugs etc.
    - Assessing levels of fear of the victim and current injuries
    - Asking about safety concerns of themselves and others e.g. children or family members and involving other services if indicated.
    - Assessing child risk and discussing the need for a safeguarding referrals
    - Identifying immediate needs such as accommodation and money/resources
    - Ensuring a safe mode of contact for follow up with the person
    - Assessing harmful coping strategies e.g. drug and/or alcohol use, self-harm and potential suicide risk
    - Assessing capacity issues.
    - Establishing plans for potential future incidences of DVA and support to implement this e.g. identifying possible escape routes, if they have a safe place to go to and information on how to contact the police/access refuge or emergency accommodation.
    - Asking what would make victims feel safer e.g. rapid police response
    - Asking if they would like to speak to an IDVA or report any incidents with the Police
    - Advise victims to keep evidence of DVA (text messages etc.) as evidence

- Acknowledgement that risk is dynamic and can change.

- Risk assessment should be undertaken by trained practitioners as there is the potential for harm in misinterpretation of DVA.

5.3 Draft statement 4

People experiencing domestic violence or abuse are offered a referral to specialist support services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Acknowledgement that there are gaps nationally in terms of who and where to refer to.
- Concerns around service availability and funding pressures.
- Referrals often to the local MARAC, adult and children's safeguarding and the police.
- General support for the emphasis on 'specialist support'.
- The need to identify 'champions' within services to act as a single point of contact and who know to refer to the MARAC and how to support other staff.
- Acknowledgement that not all people need the same level of support.
- The need to take into account the different profile and needs of different people accessing services and review local services to ensure all groups are catered for.
- The need for information in all circumstances and therefore the need to differentiate between signposting and referral.
- Offering a referral does not mean people access the help and support services required and consideration into reframing this statement.
- Multiple opportunities of referral should be offered.

- Concerns around awareness of referral pathways and support services that are in place and the need for training amongst staff on how and where to refer people experiencing DVA.
- Standardised referral forms and pathways would facilitate implementation.
- The need to share information and not be bound by patient confidentiality.
- This need for strong local partnerships to ensure information is shared and care is jointly agreed and actioned.
- The need for integrated funding for services.

5.4 Draft statement 5

People perpetrating domestic violence or abuse are offered a referral to specialist support services.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Positive comments for the acknowledgement of this being an important group for intervention.
- Acknowledgement that there are gaps nationally in terms of who and where to refer to particularly with regard to perpetrators of DVA.
- Need to define what counts as a ‘specialist’ service.
- Queries around how perpetrators are going to be identified.
- Perpetrators of DVA are more likely to come into contact with GPs, community services and mental health and substance misuse teams and the focus of statements 1 and 2 (A&E and maternity services) may have the unintended consequence of dis-incentivising the provision of support in this area.

- Concerns that services are not currently available to support this statement and that some programmes can be difficult to access and/or only available via the criminal justice system.
- Concerns around the lack of services for specific groups e.g. female perpetrators or different types of DVA e.g. ‘conflict-initiated violence’ versus ‘control-initiated’ violence.
- The need to ensure staff know the referral pathway and have access to information about services and all relevant agencies (suggestion to have policies for staff, visitors and patients).
- Concerns around increasing risk for victims by confronting perpetrators who have not disclosed this information themselves, particularly where services may not be available to deal with disclosures.
- Concerns around protecting the professionals/organisations addressing this issue with perpetrators.
- Queries around statutory requirements to contact the police, mental health services or child safeguarding specialists.
- Referral for support may not always be the right course of action - one size does not fit all. Success relies on individuals wanting to and being willing to change.
- The need for guidance on services available, when to use which services and when not to use services.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements:

- The need for information in all cases of DVA as onward referral may not always be the outcome.

- General public awareness campaigns about DVA e.g. info on safe places for disclosure made available in public places etc.
- The need for statements in specific groups who may underrepresented or at greater risk of DVA e.g. people with a disability, men, children, lesbian gay and transgender people.
- The need for a statement on information sharing between different agencies.
- An additional standard relating to the provision of specialist services, the integrated approach and setting up of multi-agency processes.
- Reinforcement of the need for a statement on multi-agency partnership working and local strategy responses.

Consultation question 9

Stakeholders made the following comments in relation to consultation question 9 which asked what specific actions should be undertaken by multi-agency partnerships or included in integrated strategies for inclusion in a potential additional quality statement:

- Map services that exist locally.
- Define the responsibilities of each agency within the partnership.
- Advertise what the multi-agency partnership provides including available support, advice and how to access services.
- Establish and outline the pathway of care for victims or perpetrators of DVA.
- Identify a single point of contact and ensure there are named DVA leads in provider organisations.
- Raise awareness of the local referral pathway.
- Establish a central multi-agency ‘hub’ responsible for factors such as timely referral and follow-up.

- Outline communication methods for services and between local agencies.
- Provide training according to national standards.
- Source best practice guidelines and link adherence to CQC visits.
- Establish and outline risk assessment tools to be used locally.
- Identify systems and arrangements for data/information sharing and action planning e.g. multi-agency meetings/conference calls.
- Establish ways to ensure diversity issues are considered and evaluated.
- Provide support services for families at risk of DVA or in crisis e.g. debt management.
- Pilot innovative approaches to dealing with DVA.
- Share best practice.
- Provide customer feedback.
- Participate in national campaigns.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[3]
28	Association of Directors of Adult Social Services (ADASS)	General	ADASS supports the development of quality standards covering domestic violence and importantly how different parts of the health and care system can work together to both respond to victims of domestic violence, as well as to take action to identify and mitigate risks of domestic violence. In terms of enhancing the draft Quality Standards ADASS notes that they need to be framed within a Social Care context, with an emphasis upon safeguarding people with care and support needs who are at risk or victims of domestic violence. Social Care works with vulnerable people within local communities either living in the their own homes or receiving care and support within residential care homes- and as domestic violence can occur in any setting, social care has, like the NHS (Quality Standard 1 & 2), opportunity to directly identify and respond to incidences of domestic violence.
28	Association of Directors of Adult Social Services (ADASS)	General	The draft Quality Standards also needs to reflect the duties upon local authorities under the **Care Act (2014)** to: • Make, or cause to be made, enquiries if it believes an adult is experiencing or at risk of abuse or neglect • Determine what action should be taken by the authority or others. Most local authorities have safeguarding adults procedures to support such enquiries and coordinate action with partner organisations • Arrange for independent advocacy to be available to adults who have difficulty in taking part in the process, and where there is no other appropriate adult to assist • Cooperate with other agencies • Establish a Safeguarding Adults Board to co-ordinate efforts by partner agencies to protect adults with care and support needs

[3]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[3]
			• Prevent care and support needs arising from abuse • Provide information about services available in the area that can prevent abuse and support people to safeguard themselves Statement 1 , 2 and 3 needs to include guidance for health and care organisations in how they engage with the local Safeguarding Adults Board on concerns, allegations or incidents of domestic violence and to reflect the role of the Local Adults Safeguarding Board to respond to such referrals or allegations. NB the Draft Quality Standards also needs to reflect upon the role of the Children Safeguarding Board.
28	Association of Directors of Adult Social Services (ADASS)	General	ADASS notes that the draft quality standards needs further refinement to reflect good practice around "Safe Referral" to cover; • Following the principles of safe enquiry and take protective measures to ensure that any discussions with potential victims of abuse are conducted in a safe environment • Understanding that victims of abuse may be reluctant to disclose what is happening to them, but that the conversation may be helping them to understand their situation better and build up trust • Asking direct questions, in a safe environment • Keeping good records of any discussions and interventions and • Following local policies, protocols and procedures at all times.
28	Association of Directors of Adult Social Services (ADASS)	General	ADASS and the Local Government Association (LGA) has developed the following guidance in February 2015 "Adult safeguarding and domestic abuse - A guide to support practitioners and managers" and a copy is attached. This guidance will be extremely relevant to the further development of these important Quality Standards and ADASS welcomes the opportunity to contribute to this work.
31	British Medical Association	General	It would be more appropriate to fit this quality standard with the other types of abuse situations that GPs have to have protocols for - such as female genital mutilation, child abuse and sexual grooming of children. All these are different shades of similar problems - with a perpetrator and a victim. There will be substantial overlaps in how GPs have to deal with them, rather than suggesting that each is a unique problem.
31	British Medical	General	We are concerned that this quality standard is going to be very difficult to deliver in the primary care setting and will

ID	Stakeholder	Statement number	Comments[3]
	Association		require an extensive educational programme.
8	Broken Rainbow UK	General	Members of the Lesbian, Gay, Bisexual and Transgendered Community (LGBT+) community may be accompanied by the perpetrator of their abuse. Often because the partner is same sex it is easy to miss or ignore the signs of DV&A. LGBT individuals should be interviewed on their own and care and consideration given to who their abuser might actually be.
25	Cheshire West and Chester Council	General	I welcome the production of quality standards and NICE's involvement in improving responses to domestic abuse. This is a serious and sadly all too common problem impacting on the mental and physical health of adults and children who are living with the effects of abuse.
25	Cheshire West and Chester Council	General	It is important to keep general practice pharmacists and dentists advised of possible signs of abuse and of action that could be taken since I feel that people may use these services to deal with problems which may be caused by abuse
25	Cheshire West and Chester Council	General	There should be a quality statement included that highlights the need to consider Safeguarding Children issues if dealing with a DA situation.
25	Cheshire West and Chester Council	General	Paragraph 4 starts with "multiagency partnership" and finishes with sentence on training requirements for healthcare professionals……should this last sentence also refer to multiagency professionals too?
3	City Health Care Partnership CIC	General	City Health Care Partnership CIC is a "for better profit organisation", providing healthcare to people living in Hull, the East Riding of Yorkshire and the North West. We are committed to providing excellence in patient care and feel passionately about preventing and managing domestic violence and abuse. We developed a small working group made up of our safeguarding leads, senior clinicians and managers to review and respond to this consultation. The outcomes of which are outlined below. **1. Does this draft quality standard accurately reflect the key areas for quality improvement?** **CHCP CIC response:** We feel that the quality standard partially reflects the key areas for quality improvement. For example, all the statements are relevant, and the need to offer a private one to one discussion with women presenting at maternity services and people presenting at A&E are valid. However we have identified that: • ***Routine enquiry*** should be adopted in maternity – all women should be offered a private one to one discussion. Pregnancy itself is a risk factor for domestic violence, in relationships where this has not previously occurred. Pregnancy can also act as a trigger for an increase in the frequency of severity of domestic violence. ***All*** pregnant women are potentially at risk, therefore offering routine enquiry to all, with a clear explanation that this is a universal initiative, can reduce the associated stigma that may occur if midwives are thought to be singling out certain groups within the community. • In A&E all people, for example those with injuries should be seen, for at least part of the consultation, on their own, and asked about domestic violence. • The standards should consider offering this level of support in other areas of care such as: • Minor Injury and walk in services – as not all service users will present in A&E but may instead attend

ID	Stakeholder	Statement number	Comments[3]
			community based unplanned care services • Unplanned pregnancy and abortion services – not all pregnant women will access a maternity pathway and evidence suggests that women attending for abortion may be at 6 times high risk of domestic violence than those attending maternity services: (Ref: Wokoma et al; 2014: A comparative study of the prevalence of domestic violence in women requesting a termination of pregnancy and those attending the antenatal clinic; BJOG; volume 121; Issue 5, pages 627-633). Therefore we feel the standards should include care via unplanned pregnancy and abortion services in addition to maternity. • Other providers of healthcare, such as the patient's own GP, dentist, school nurse or health visitor may also be in an ideal position to identify and support people who are affected by domestic violence and so we would recommend the inclusion of a standard for these members of the healthcare team/services. • Offering in sexual health services would also be beneficial and provide close links to violence, abuse and sexual exploitation pathways and services.
48	County Durham and Darlington NHS Foundation Trust	General	Note the abuse of a standard requiring referrals without consent in situations of high risk.
44	Cumbria Partnership Foundation NHS Trust	General	Should include Minor Injury Units, Pcas, & walk-in centres/pharmacies
44	Cumbria Partnership Foundation NHS Trust	General	CAADA risk assessment should be utilised in the assessment process
44	Cumbria Partnership Foundation NHS Trust	General	Over 16 yr old -18 yr old – Teenage Relationship Abuse – new definition
44	Cumbria Partnership Foundation NHS Trust	General	Private should offer security from potential perpetrator
21	Department of Health	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	The Faculty of Forensic and Legal Medicine (FFLM) is a charity set up to develop and maintain the highest possible standards of competence and professional integrity in forensic and legal medicine. The FFLM covers professionals working in three related disciplines: forensic medical practitioners (forensic physicians, forensic pathologists, sexual assault examiners, and child physical and sexual assault examiners, forensic nurses and paramedics); medico-legal advisers; and medically qualified coroners. The FFLM is very disappointed that this document fails to identify the role of the expert forensic specialist, often working in conjunction with other disciplines (such as paediatrics) in identifying and recording signs of domestic violence. These signs may not be physical, and they may not lead to police action, prosecution or the need for expert evidence in court, but it is essential that expert documentation of any physical or mental injury is undertaken, as well

ID	Stakeholder	Statement number	Comments[3]
			as an expert view being given on the likely cause of injuries. NICE will also be aware of the risk in this area of the identification of injuries that are not due to abuse, as well as issues of false reporting. In processing a case of suspected abuse that can be identified as at least dubious, and in some cases clearly due to other factors, such as medical causes of easy bruising, early mistakes in identifying such cases as domestic abuse can lead to very distressing and unnecessary decisions. Overall, the failure of these draft standards to include the use of professionals trained in identifying abuse, in documenting evidence, and being able to give authoritative evidence in court, is serious, and makes the draft standards of limited value. Specifically, the role of Sexual Assault Referral Centres (SARCs), which are of value in cases of non-sexual abuse, is essential. SARCs provide a multidisciplinary approach to investigation, risk assessment and treatment, using paediatricians, gynaecologists and forensic specialists in a team that takes a holistic approach to the problem. **The FFLM calls on NICE to consider a redraft.**
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	The FFLM is recognised as the standard-setting body in the forensic examination of alleged victims of crime, and of detainees in police custody. The Faculty has developed both detailed guidelines and curricula on standards and education of practitioners working in this field, and in specific areas such as domestic violence and sexual abuse. It is regrettable that these resources are not included in the draft standards, as they represent an existing and authoritative set of guidance and standards in the area of domestic violence. In addition the FFLM identifies and recommends authoritative training programmes in this field, and can offer such advice as part of a quality assurance that training programmes for all practitioners involved in this area include the identification of domestic assault, and an approach to support and treatment of alleged victims.
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	Again, the FFLM recommends that the identification, treatment and support offered by forensic practitioners and SARCs, should be included
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	Safeguarding decisions need to be taken on the basis of expert evidence as to the likely nature, extent, frequency a severity of alleged abuse. This requires an overall assessment that includes a forensic examination.
26	Faculty of Forensic and Legal Medicine at the Royal College of	General	The FFLM has a variety of guidelines on these issues which should be referenced.

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	Physicians of London		
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	We note that the team includes specialists such as an oncologist and a vascular nurse specialist, but not a forensic practitioner. This is in our view difficult to justify.
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	General	These draft standards cannot be accepted in their current form. The FFLM will not be able to support or recommends ham to practitioners. We will be delighted to assist with any proposed redrafting, which will entail a major rewrite to reference specialist input throughout the document.
1	General Medical Council	General	We are an independent organisation that helps to protect patients and improve medical education and practice across the UK. Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified. One of the ways in which we do this is by setting the standards that doctors need to follow, and making sure that they continue to meet these standards throughout their careers. We welcome the introduction of this quality standard and the aim to improve the services provided to people who experience domestic violence and abuse. Doctors must make the care of their patients their first concern. We already say in our guidance that we expect doctors to do their best to provide support and information to people who experience domestic violence (paragraph 51, *Confidentiality*), and while offering support services to perpetrators of domestic violence is not specifically mentioned in our guidance, it is entirely compatible with it. Providing patients with the opportunity for a private discussion is also in line with the principles of our guidance, as doctors must respect the privacy and dignity of their patients (paragraph 2, *Good medical practice*).
1	General Medical Council	General	We understand that the aim of the quality standards is to achieve measurable improvements, and collecting data is essential to this. When implementing this quality standard, local providers will need to take into account that doctors must follow our guidance on confidentiality. Broadly this means that any process or outcomes data used for monitoring this quality standard will need to be anonymised or coded, unless there are specific reasons not to do this, as set out in paragraphs 40-50 of our *Confidentiality* guidance.
50	Hampshire Domestic	General	Where there is mention of training, there also needs to be consideration and commitment to providing relevant

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	Abuse Steering Group		funding to provide the necessary training. Accompanying funding is often overlooked, resulting in an inability to actually provide the training.
37	Leicestershire Partnership NHS Trust	General	It would be beneficial for NICE to produce a more user friendly companion document about implementation of the standards that is accessible to practitioners. As a standard it is as it is, however, it is long-winded and turgid and will very probabaly only be read by commissioners and NHS managers. There appears to have been a missed opportunity to add additional focus onto mental health and substance misuse services.
36	London Borough of Enfield	General	The quality standards would more accurately reflect the NHS if it included general practitioners, the most used service within the NHS. This is critical to ensuring a whole system approach and a gaping hole without their inclusion.
36	London Borough of Enfield	General	Whilst substance misuse and mental health are included in equality and diversity considerations there is nothing specific for people experiencing domestic violence and abuse with these additional needs. Given the numbers of survivors experiencing domestic violence and abuse that also have substance misuse and/or mental health problems it would be sensible to have a focus on the most vulnerable survivors and include a quality standard for this particular issue.
36	London Borough of Enfield	General	The standards are welcome in highlighting basic good practice but fall short of being able to implement quality. It's noteworthy these standards have been in circulation for a considerable number of years however they are failing to address areas needed for urgent action and to link in with local strategies, integrated work, training and all NHS services which need to include general practitioners.
17	NCSPVA, University of Worcester	General	It is reassuring to read that NICE have identified the importance of consulting with women, men and young people who have experienced domestic violence and abuse as part of this assessment. This will ensure that the voice of those affected may be heard in terms of their experiences of the health system and what would be effective.
53	NHS England	General	Thank you for an opportunity to reply to the draft guidance. The standards are clear and I welcome that they covered both providers and commissioners. Just a few minor points for your consideration are: The Care Act was only mentioned once and this could be added into each standard with a statement about the duty to act under the new statutory duties.
18	NHS Solihull CCG	General	Introduction sets out who this standard covers however, whilst there is emphasis on 16 plus and questions in respect of 'at risk groups'. The document could benefit from explicitly mentioning risk groups in regards to domestic violence across older people and those who care for others who have care and support needs. Unfortunately a few local domestic homicide reviews have shown that carers are not adequately being identified as potential risk groups either.
	NHS Solihull CCG	General	In respect of the consistent message about commissioners to "ensure that health care professionals are trained to recognise the indicators of possible domestic violence and abuse, make kind and sensitive enquiries as part of private one to ones". However, please note the employers are responsible for knowledge, skills and competencies of

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			their own workforce and how they organise they facilities. Commissioners can ensure they include national and locally agreed standards, to which we currently do have locally agreed domestic abuse standards that also apply to own workforce disclosing domestic abuse and how the employer should manage such disclosures. We can, as we have done so, use information requirements so that commissioners can see numbers relating to domestic abuse reported under safeguarding children (use of DVRIM (Barnados matrix) and LSCB thresholds documents) and referrals into MARAC, encouraging the use of CAADA DASH risk assessment tools etc. We can ask for learning and development across the workforce however, as these are contractually negotiated there is no guarantees that commissioners can 'ensure' the process despite the best intentions. The best place to 'ensure' - is for domestic abuse to be explicit within the NHS Standards Contracts- Service Specification (e.g. similar to the Prevent agenda). The standard therefore should apply to the Department of Health, including standard contracts and service specifications related to Primary Care Medical Services and other Independent Contracts. Post NHS Reforms, the other weak area for safeguarding and public protection in respect of commissioning, is specialised commissioning. Hopefully by placing the standard firmly within NHS Standard Contracts etc..you'll be securing a more robust measure and response and then, locally we can use the central contractual levers to bring about changes needed.
18	NHS Solihull CCG	General	In respect of the wider 'commissioning funds'. Whilst there is an overlap with respective Health and Well-being, Health Watch bodies. Partnership priorities around domestic abuse are frequently set within the Community Safety Partnerships, Local Police and Crime Boards, scrutinised by Crime and Disorder Scrutiny Committee and/or panels. Funding for specialist and specific services for domestic abuse is frequently commissioned via the Police and Crimes Commissioner and/or funding from central government e.g. Home Office. Our area, and within its constraints, has been very proactive in commissioning across the partnership for services for victims and trying to obtain better resources for managing perpetrators. However, the Police and Crime Commissioner does' not know what funding will be allocated from one year to the next. This severely undermines any local or regional attempt to ensure long term and sustainable services. The problem has been formally articulated by us and the Council Domestic Abuse Co-coordinator both to the Health & Wellbeing Scrutiny Boards and Crime and Disorder Scrutiny Panel but I am afraid, these NICE standards do not seem to address the underlying problem that is ultimately determined by central governments funding allocations.
18	NHS Solihull CCG	General	Owing to the time constraints we have not been able to formally take the quality standards through our governance process however; our organisation takes it statutory responsibilities to safeguard children, young people and adults at risk of harm as a major priority for the organisation and for our work with local partners. Final published standards will therefore be tabled and considered at our respective Governance committee's and partnership boards.
18	NHS Solihull CCG	General	Our local partners are coordinating a joint response and therefore specific standards have not been commented on in this submission.

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30	R.I.S.E.	General	Definition of domestic abuse provided in the document does not mention FGM when it is a form of DVA.
46	Refuge	General	Refuge is pleased that the government continues to engage with the significant and wide ranging health impacts of domestic violence upon women, children and young people and that it is striving to develop quality standards to meet their needs. The experience of serious, life threatening injuries, persistent assaults and/or psychological abuse mean that many of our clients require significant specialist input to overcome these difficulties. A third of all women arrive at Refuge's safe houses with a current or recent injury and 20% require urgent medical treatment; most are traumatised and around 10% experience thoughts of suicide. We are therefore proud that in the last financial year we supported women in our refuges to achieve 97% of the health outcomes they identified. We hope to continue this success and expand our capacity to meet the health needs of women and children in a range of settings, as well as to engage with government in defining and rolling out standards of the highest quality for this group of women and children. Refuge has long recognised the health needs of abused women and their children - with Department of Health funding we expanded our pioneering child psychology programme, carried out the first research project into the impact of domestic violence in pre-schoolers in the UK and we further developed our women's psychotherapy/psychology service. We also carried out in-house research into the overlapping psychological impacts of domestic violence on women and children. As a major stakeholder, Refuge has responded to many government consultations, participated in Department of Health roundtables and played an active role on the DoH task force of 2009-10. In recent years Refuge has developed successful advocacy services within health settings, ensuring abused women and their very vulnerable new borns, receive timely specialist domestic violence support when they need it most. We also work to raise awareness about domestic abuse across health services and have employed an IRIS educator to work in partnership with a local clinical lead across 25 GP practices; they will train primary care practitioners in the early identification of domestic abuse, appropriate care pathways and provide an enhanced referral route in to Refuge's services. Throughout the interactions described above, we have always been clear in our message that services and initiatives for women and children must be integrated. Domestic violence happens to women and children in the same household, often at the same time and with overlapping consequences for both. We know that babies are at greatest risk of homicide across England and Wales today and that an estimated 39,000 of them live with domestic violence. Serious case reviews tell us that the context of domestic violence represents a significant risk of serious or fatal harm for children and our own experience of supporting families bereaved through domestic violence frequently reveals glaring errors in a multiagency system where services and risk
46	Refuge	General	Identification and referral to improve safety. "As in previous years, children under one year old had the highest rate of homicide (23.9 offences per million population) compared with other age groups". Crime Statistics, Focus on Violent Crime and Sexual Offences, 2013/14. www.ons.gov.uk Dr Manning, V. (2011) Estimates of the number of infants (under the age of one year) living with substance misusing

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			parents (NPSCC) Cuthbert C., Rayns,G., Stanley, K. (2011) All Babies Count. Prevention and Protection for Vulnerable Babies. Analysis of serious case reviews in England revealed that domestic violence was a factor in the lives of 63% (n88) children who were seriously harmed or killed between 2009-2011. Brandon M, Sidebotham P, Bailey S, Belderson P, Hawley C, Ellis C, Megson M. New Learning from Serious Case Reviews: A two year report for 2009-2011.
41	Research in Practice	General	There should be more information included on the prevalence and impact on children of experiencing domestic violence, including the association with abuse and neglect and the impact on children's mental health and other outcomes. • 18% of children and young people aged between 11 and 18 have experienced domestic violence in their life time (Radford et al, 2011) with 4% exposed to severe domestic violence. • 8% of young people aged 11-17 and 12% aged 18-24 have experienced intimate partner violence (Radford et al, 2011) • 40% of referrals to children's social care had an element of domestic violence (DfE, 2014); children experiencing domestic violence are nearly three times as likely to experience abuse or neglect than their peers (Radford et al, 2011) and is one of the most frequently mentioned characteristics of cases subject to serious case review (Brandon et al, 2009) the association between experiencing domestic violence and mental health difficulties and behavioural difficulties in school-age children and older young people and into adulthood (Stanley, 2011)
41	Research in Practice	General	Age should be included in the list of assumptions that professionals may make about risk of domestic violence. 16 and 17 year olds should be added to the list of people who may find domestic abuse services difficult to access.
41	Research in Practice	General	For more information on these points, please see the Research in Practice Research Review on Children Experiencing Domestic Violence. This is cited as Stanley 2011 above and a copy can be made available on request.
51	Royal College of Emergency Medicine	General	The Quality in Emergency Care Committee (QECC) do not have any specific comments to make on the draft domestic violence quality standard at this stage, but welcomed the opportunity to be involved in the consultation.
10	Royal College of Obstetricians & Gynaecologists	General	We particularly welcomed the emphasis on providing opportunities for one to one discussions with women presenting to A&E, Maternity or other services for discussions. However, some challenges in making this a reality in terms of time, setting and the need for training of staff should be acknowledged
10	Royal College of Obstetricians & Gynaecologists	General	All sections: sceptical about how either the numerators or denominators could be identified with any degree of reliability in clinical practice
13	SafeLives	General	This quality standard is a step forward and is a useful lever for change. However, without a real pressure to include this in an integrated commissioning approach which aligns with/complements PCC and LA commissioning these won't happen on the ground. There need to clear and solid links between confident universal staff (with confidence unlocked by a combination of training, a known Idva/Advocate Educator/DVA specialist to refer onto, and an in house

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			champion), quality, accredited specialist services and commissioning responsibilities.
20	Sanctuary Supported Living- Housing Association	General	Feedback includes questions around ensuring that there are trained staff who are appropriately trained to complete a DASH risk assessment, ideally resources should be available to fund Safe Lives trained IDVAs.
9	Sheffield Children's Hospital	General	There is a discrepancy between the statement that the standards relate to under 16 year olds, and the content, which does not differentiate children from adults. We feel that children who have witnessed or been part of a domestic violence situation have specific needs. The document should therefore either remove the statement that children are covered or it should give specific recommendations and standards for children who are involved in domestic violence.
49	Sheffield City Council	General	We have started to use domestic 'and sexual' abuse as our terminology as this is more inclusive of the issues faced by victims. I would suggest consideration is given to using this terminology in the guidance.
49	Sheffield City Council	General	There is not much in the guidance about sharing information. We have introduced a local process for seeking information re. people being discussed at MARAC from GPs and this is being questioned by the LMC – it would be helpful for the guidance to explicitly support sharing of information where relevant and appropriate and for the purpose of managing risk to victims and their dependents.
49	Sheffield City Council	General	Interpreters – I support the wording used but would like to also see reference to interpreters preferably being trained on how to ask questions around domestic abuse and how the term domestic abuse is interpreted in different languages e.g. in Urdu there is no direct translation. This is learning from a recent (as yet unpublished) Domestic Homicide Review in Sheffield. There should be some guidance developed around how to interpret / translate the meaning of the phrase 'domestic abuse' into different languages. But it's also important that in any language used, interpreters and indeed any professional, has had training in asking open questions on this subject e.g. how do you and your partner resolve arguments?
49	Sheffield City Council	General	Re. ***What the quality statement means for service providers, healthcare professionals and commissioners – healthcare practitioners:*** Staff should be trained in supporting disclosures – we often hear about staff lack of confidence in asking the question. As above, training should be provided in training in asking open questions on this subject e.g. how do you and your partner resolve arguments?
49	Sheffield City Council	General	Page 20 ***What the quality statement means for service users*** **People experiencing domestic violence or abuse.** I think it is problematic that the list of possible services starts with refuges. The vast majority of people experiencing domestic abuse do not use a refuge. I think starting with helplines (local or national), outreach services, drop in/advice centres would be better. Offering refuge as the first option is enforcing the idea that this is the primary solution and it is not – it is a solution among many. It is better worded on page 21 although this paragraph does not mention helplines. There is also no mention of sexual abuse services including Sexual Assault Referral Centres.

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49	Sheffield City Council	General	Page 22: re. the section: ***Equality and diversity considerations*** Services should be tailored to address the specific needs of people experiencing domestic violence or abuse. Services should include those to help prevent forced marriages, to help men, and lesbian, gay, bisexual or transgender people affected by domestic violence or abuse, and to help people subjected to 'honour' violence or stalking. This should be reworded as follows: Services should be tailored to address the specific needs of people experiencing domestic violence or abuse, including offering support to help prevent forced marriages, to help men, and lesbian, gay, bisexual or transgender people affected by domestic violence or abuse, and to help people subjected to 'honour' violence or stalking. Not every area has specific FM /HBV / men's / LGBT services and so 'general' services must be able to meet the needs of all victims locally.
22	The ManKind Initiative	General	We are not convinced of the merit in the paragraph starting (Both men and women perpetrate...) as the figures in the previous paragraphs show that there is a ratio of 2:1 for women and men. To then place the extra emphasis and description on the gender split through this additional paragraph has the narrative effect of downplaying male victims – when all victims need to be recognised as equals based on individual need. This guidance should be about individuals with their gender as secondary (albeit important features) so the existence of the paragraph is not helpful and should be removed as it relegates men to being second class victims.
40	The Royal College of General Practitioners (RCGP)	General	This is a thoughtful and inclusive document. It would be helpful to have an indication of how effective the interventions suggested are, and how good the evidence base for them is. [PS]
40	The Royal College of General Practitioners (RCGP)	General	GPs should be aware of varying cultural differences. The safety of the patient must be paramount. [PS]
40	The Royal College of General Practitioners (RCGP)	General	Evidencing the problem of Domestic Violence can be challenging, this includes the difficulty of people witnessing against a partner or family member. [PS]
40	The Royal College of General Practitioners (RCGP)	General	The threshold of suspicion and the possible damage when someone is accused or suspected falsely needs to be carefully considered, including in a treatment situation where the impossibility of a therapeutic relationship once trust has been lost. [PS]
40	The Royal College of General Practitioners (RCGP)	General	The problem of the persecutor/victim/rescuer triangle should be clearly identified in the document, and that some people return repeatedly to abusive relationships and that people can also switch roles in the triangle. [PS]
40	The Royal College of General Practitioners	General	Once those at risk of Domestic Violence have been identified it is important that services respond to the needs of the individual affected, and that support services are tailored appropriately. This QS attempts to highlight the need for

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	(RCGP)		such support and provides exemplars of how affected individuals may present. [IR]
11	The Royal College of Midwives	General	RCM welcomes this quality standard which covers several of the key areas that need quality improvement. The comments in this response are based on feedback from midwives who reviewed and responded to the Royal College of Midwives on this draft quality standard.
11	The Royal College of Midwives	General	Again all women need to be asked about DA as they don't always present as a victim.
11	The Royal College of Midwives	General	If the systems and structures were available it should be possible to collect the date for the proposed quality measures
15	The Royal College of Psychiatrists	General	There is a lack of mention of mental health services which strikes us as a missed opportunity. This may be because there is an assumption that everyone in contact with mental health services will be asked about domestic violence but this is not the case; people in contact with mental health services (including IAPT services) are particularly likely to have experienced domestic violence (Khalifeh et Al Psychological Medicine 2014 found 27% of women mental health service users for example reported recent - within last year - domestic violence and more than 60% had experienced domestic violence since the age of 16). We believe there should be a requirement for mental health service users to be asked about domestic violence. They need to be asked about DVA in private and on a one to one basis. We know from many studies that this is not currently happening in routine care.
22	University of Central Lancashire (UCLAN)	General	The generic word 'people' is unlikely to pay attention to the specific needs of particular groups of people unless this is articulated in the quality statements. The equality and diversity statements are too generic to be useful to practitioners.
22	University of Central Lancashire (UCLAN)	General	regular monitoring of the effectiveness of local partnership arrangements (service users and agencies), pay greater attention to diversity issues. For example in relation to BME women, no recourse to public funds is a recurring theme in the research literature and there is anecdotal information that health and social care professionals operate a 'culture of suspicion' based, presumably, on lack of knowledge about what women with no recourse are entitled to. The same is also applicable to professional responses to asylum seekers and possibly other categories of migrants.
42	Women's Aid	General	Women's Aid is the national charity for women and children working to end domestic abuse. We are a federation of over 220 organisations providing more than 300 lifesaving services to women and children across England. Women's Aid welcomes the development of the Quality Standard and restrict our comments to our areas of expertise. In the introduction we would suggest using the cross Government definition of domestic violence: https://www.gov.uk/government/news/new-definition-of-domestic-violence-and-abuse-to-include-16-and-17-year-olds
42	Women's Aid	General	We believe that the introduction could include more information about the gender specific nature of domestic abuse. We would suggest including the pieces of research below: - 89% of victims who experience four or more incidents of domestic abuse are women:

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			http://www.avaproject.org.uk/media/28792/hors276.pdf - The ONS Crime Survey for England and Wales statistics underestimate the levels of violence against women. This is because the number of incidents asked about in the survey are capped at five. Professor Walby's research uncaps them and finds a much higher proportion of violence against women: http://www.research.lancs.ac.uk/portal/en/publications/mainstreaming-domestic-and-genderbased-violence-into-sociology-and-the-criminology-of-violence(75b60f8e-041c-4ba6-aa47-1b3a7ee7c5bb).html
54	Youth Justice Board	General	The definition of a child should be clearly stated along with the other definitions in the document to ensure that all children and young people (cyp) under 18 years old are equally protected. The consultation makes reference to under 16 years old and it is important that 16 and 17 year olds are equally considered as children as per the definition which is used across the youth justice service. (The UN Convention on the Rights of a Child defines a child as everyone under 18 years old). Professionals working with cyp should be mindful of the particular safeguarding and legal frameworks that specifically apply to all under 18s. Young people within the Youth Justice system are often identified as offenders rather than possible victims of domestic violence and abuse which should also be considered and identified if appropriate as part of the initial assessment.
54	Youth Justice Board	General	We recommend that due to the shared jurisdiction between England and Wales that the standards should be applied in similar ways and highlighted as such as part of the introduction.
39	AVA (Against Violence and Abuse)	Question 1	It is vitally important that there is a standard relating to the quality and quantity of training required for staff in order to ask questions and make appropriate referrals. Training features as a major part of the NICE guidance and is the foundation for the other recommendations. AVA have been commissioned by PHE to develop an e-learning to support the training outlined in the NICE guidance. This training material has been completed, signed off by Public Health England, and will be launched imminently . This should be the very minimum expected of NHS staff and should also be supplemented by face to face training as part of any standard safeguarding package. Evidence tells us that there are many barriers to health care professionals inquiring about domestic violence and abuse (Rose et al) and it is essential that staff are trained so that they are confident and competent both to enquire about domestic violence and abuse , and to respond appropriately to disclosure.
39	AVA (Against Violence and Abuse)	Question 1	Without a standard relating to partnership working and local strategy responses, there is a danger that the standards will lead to overstretched and overburdened staff. In addition to adequate training, front line staff need to be supported by managers and strategic leads within the NHS service which should be further embedded within a local strategy response with Health and Well-being Boards and Clinical Commissioning Groups.
39	AVA (Against Violence and Abuse)	Question 1	It is important to include a statement specifically relating to younger people (under 21, or vulnerable adults under 25) as currently this age group are often sent to services which are designed for adult women and not appropriate or safe for young people.

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39	AVA (Against Violence and Abuse)	Question 1	The five standards as they stand could be amalgamated into one: ensure patients presenting with indicators of possible domestic violence receive a response including: being asked privately, being assessed for safety and referred to specialist services. In this way additional quality standards mentioned above could be included.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 1	**Does this draft quality standard accurately reflect the key areas for quality improvement?** The quality statements do not sufficiently emphasize the overwhelming importance of supporting basic awareness training on domestic abuse for all healthcare workers and practitioners; which underpins any model of response to domestic violence (DV) in a hospital setting. It cannot just take place once, but must be ongoing to ensure that existing staff are updated and new staff are trained. To implement the quality statements organisations need to have robust training in place to ensure that all steps of the process are followed correctly. The training must be supported by clear departmental/Trust guidelines which include details on how to ask the questions, how to respond to disclosures, when and how to refer patients following a disclosure and clear referral pathways. The draft quality standard recommending patients with indicators of domestic violence and abuse should have a private consultation falls short of best clinical practice as every patient should have this as a matter of course. If this is not standard practice it is difficult to understand how this quality standard could be implemented in a confidential way as the service user would need to have a consultation in order for the indicator to be identified and would then need to be taken somewhere to have further discussions. The draft quality standard recommends a discussion in people presenting to services with indicators of possible DV however as this is often difficult to assess, routine enquiry about any experience of domestic violence and abuse in certain areas (e.g. antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services), as per the NICE 2014 guidance, may be beneficial. This would not only increase disclosure in those do not present with indicators or where indicators are missed by clinical staff, as studies have shown that spontaneous disclosures are rare, but would also de-stigmatise the enquiry. Co-location of IDVAs within hospitals/healthcare settings need to be considered as a key strategy to a coordinated response for survivors. Finally, additional quality improvement areas include overall awareness campaigns for the general public about the prevalence of DV with the aim of informing survivors where the safe places for disclosure are, as well as ensuring that staff have awareness of services available and information is clearly displayed in waiting areas and other suitable places about the support on offer for those affected by domestic violence and abuse.

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			Engaging with perpetrators also needs more specialist training, staff need to be aware of existing services and patient information needs to be available.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 1	Key areas included
25	Cheshire West and Chester Council	Question 1	The draft Quality Standard accurately reflects all key areas for improvement.
3	City Health Care Partnership CIC	Question 1	**CHCP CIC Response:** Yes we are confident that with the appropriate systems and structures, it would be possible to collect data for the proposed quality measures. For example, we feel the use of Electronic Patient Record (EPR) systems, with the associated use of approved "read codes" will enable healthcare providers to determine how many people have been assessed and commenced on the appropriate care pathway. The EPR system would be key to monitoring compliance to the standards. Use of Electronic Staff Record (ESR) systems can also be utilised to identify level of uptake of domestic violence training for staff. There should be a requirement for providers to provide evidence of meeting the standards, for example by inclusion of this by the Care Quality Commissions (CQC) as part of their review and registration of care providers.
48	County Durham and Darlington NHS Foundation Trust	Question 1	Whilst the vulnerability of particular client groups is well researched, where there is any suspicion of domestic abuse with any individual, irrespective of the healthcare setting or whether due to the nature of injuries or presentation/ comments from client then sensitive confidential enquiry should be undertaken. Enquiry must take place in a safe way, preferably one to one and in a private place. Clearly the partner should never be involved. Should the person have a learning difficulty or capacity issue then consideration may need to be given to an appropriate adult being present. Questionable whether an independent interpreter could / would always be used for all 1:1 in certain settings. It can be however be difficult in busy health settings to find a safe space / opportunity - staff may need to be creative in making those opportunities for enquiry. Staff need to be fully aware of what to do in response to disclosure i.e. appropriate referral, identifying others at risk e.g. children, ensuring immediate safety of those involved, liaison with appropriate professionals. Only staff who are trained should make enquiry to prevent any unsafe practice. Good record keeping and body mapping of injuries is essential as they may later be required for evidential purposes

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			Most issues in this section are underpinned by training. Domestic abuse training has not previously been a uniform mandatory requirement nationally hence all NHS organisations will have a significant resourcing issue in terms of ensuring staff are appropriately trained. Training all A&E staff to a level required may be problematic due to high turnover of staff – perhaps consider training a cohort of staff to level 3 to carry out 1:1 but all staff have level 2 training to ensure that they are able to recognise indicators of possible domestic violence or abuse. **Data collection** - could be collated using a simple data collection tool – providing locally used IT systems are able to accommodate this. **Privacy definition** - alone in a room with a closed door, with the health professional. Children should not be present (risk of inadvertent disclosure to perpetrator) **Application to other areas**: Clearly A+E departments are a key area but this should also apply to walk in/ urgent care centres.
24	Durham County Council	Question 1	IDVA training of healthcare professionals within these prominent locations would increase access to on-site services which benefit these vulnerable victims, for example drug and alcohol, mental health and safeguarding nurse teams. In this way victims would be offered a complete package of immediate support. Inclusion of GP's into the quality standard would be beneficial. A high proportion of victims present to GPs with various indicators of domestic abuse. It would be helpful to include them in the quality standard. It would be helpful to include reference to children within the quality standard. Children may present to A&E and other services due to domestic abuse occurring within the household. For example a recent presentation by Carlisle Foundation Trust highlighted a case of a child using asthma symptoms to diffuse the situation within the home when domestic abuse was occurring, this led to frequent visits to A & E from the child.
50	Hampshire Domestic Abuse Steering Group	Question 1	*Does this draft quality standard accurately reflect the key areas for quality improvement?* You need to define exactly what you mean by a 'presentation' of DV/A otherwise there will be wildly differing interpretations and standards across different services, making comparisons impossible.
47	Institute of Health Visiting	Question 1	In part. Although it does miss out some important health provision, including health visiting. We believe health visitors are well-placed to recognise and respond to domestic violence and abuse. We are particularly concerned about ensuring staff are adequately trained and supported to work effectively in this field. To this end, the Institute of Health Visiting (iHV), in conjunction with Women's Aid, developed a bespoke

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			learning package and trained 266 experienced health visitors (HVs) to become Domestic Violence and Abuse (DVA) Experts with a responsibility to provide leadership, learning and influence at a local level. The programme of learning, which was launched in Autumn 2013, was supported by finding from the Department of Health (England). At this time the NICE Guidance PH50 was in consultation form, but referenced in our training as an important information source for HVs. We found it very helpful indeed. The DVA experts are now cascading their learning to health visiting colleagues and student health visitors. As part of this initiative we also developed a complementary e-learning package. We expect the DVA programme of learning to reach the entire health visiting workforce and for it to provide an important opportunity for quality improvement. DVA is a sensitive and difficult area for all staff, but particularly for newly and recently qualified health visitors, so iHV have established a clear standard for preceptorship and staff support. We would also note the need to ensure staff safety in potentially violent situations, particularly in the home, in addition to our concerns for the victim and their children. Staff safety clearly applies in other services too.
14	Leeway Domestic Violence and Abuse Services	Question 1	Yes in my opinion it adequately reflects the key areas.
45	Mid Essex Hospital (NHS) Services Trust	Question 1	Why are the statements limited to Acute Trusts in the form of Emergency departments (A&E) and maternity only? We know that most victims and abusers are most likely to have interactions with their local GP practice and often with their mental health and associated health providers. Why are these not included in this document at all. Surely this Quality Statement should not be restricted to the acute Trusts, but should apply to all patients and service users attending a medical appointment whether that is at an ED, GP or mental health facility Statement 1&2 should be merged to cover all health providers overseen through the CCG commissioning process and also GPs. In this way people experiencing or perpetrating abuse will be considered at any stage of the health continuum it will not be only one relatively small aspect being held to account. Additionally by concentrating on A&E and maternity you are continuing the stereotype that DVA really only affects women. We know that women suffer more severe violence from men than the other way round, but coercive control, physiological and emotional abuse can affect men equally and they are more likely to attend a GP practice, mental health or substance abuse provider than A&E. Older people, same sex relationships and abuse of people with care and support needs are more likely to be reported to a GP or district nurse than either of the two locations subject to the statements so again the requirement to ensure

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			there are trained staff, an understanding of DVA and the ability to offer support and guidance must not be limited to the Acute and maternity sectors. Reviews of the DHR carried out in Essex indicate that GP, community and mental health services have significant areas for improvement to ensure that all people experiencing or perpetrating DVA are given the opportunity to disclose abuse and be supported in their situation. As an additional point, it might be more appropriate in this era of growing understanding of a wider range of abuses to have a mandatory one to one conversation with all patients and service users as part of the initial consultation to cover all types of abuse. This would still only require a few questions
34	NIHR CLAHRC North Thames	Question 1	***Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?*** • The important areas for quality improvement in domestic violence and abuse are: 1. Safe identification of victims and perpetrators of DVA. 2. Accurate recording of DVA in health, social care and police records. 3. Assessing safety and taking appropriate steps to address safety. 4. Timely referral into support services, guided by a person-centred approach. 5. Training in DVA for professionals across a variety of health and social care settings to achieve 1-4. 6. Joint planning, commissioning and evaluating of integrated pathways of support for victims of DVA to achieve 1-5. 7. Involvement of people affected by DVA in design and evaluation of services. • This draft quality standard addresses identification of victims in two important health settings – maternity and emergency services – as well as raising the issues of safety assessment and referral for support, for both victims and perpetrators. • Though acknowledged, it does not accurately reflect the importance of training as a priority first step in order to achieve identification, safety assessment and referral for support. This training should not be generic DVA awareness raising training but specific health focused training so that clinicians can recognise how DVA presents in their consulting rooms (i.e. including real cases); and the importance in identifying DVA for providing competent and compassionate clinical care (e.g. it is clinically incompetent to diagnose depression and prescribe antidepressants without having taken a history enquiring about DVA). This clinical DVA training needs to be delivered by a local influential clinician who is interested in DVA rather than solely by DVA

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			specialists from an advocacy background. Clinical DVA training should also be delivered in-practice, to the primary healthcare team which normally works together so that local knowledge and experience can be fully utilised, including the discussion of difficult cases (e.g. when DVA overlaps with child safeguarding). • The draft quality standard also does not consistently emphasise that joint commissioning of integrated services underpins improvements in the care and support of victims of domestic violence. The Care Act 2014 imposed a duty on Local Authorities to employ multi-agency approaches, with domestic violence explicitly recognised as an adult safeguarding issue. This should be mirrored in guidance for health professionals. • On the issue of joint commissioning, use of the term 'may wish to' in the following statements should be amended to read 'must'. '*They may wish to adopt a multi-agency approach and work with health and wellbeing boards and local strategic partnerships on domestic violence and abuse'* • The draft quality standard does not highlight training in the safe identification of perpetrators as a priority, and does not make explicit reference to the importance of safely recording information about DVA or how this can be achieved. • The draft quality standard does not recognise the crucial importance of involving people who have been victims of DVA in improving quality of DVA services. • It does not address other health care settings where DVA could be identified: - Primary care - Sexual health - Mental health - Drug and alcohol services • It does not address the needs of children who have witnessed abuse of a parent or relative, which differs from the needs of children who have been directly abused as will be covered in the future quality standard on child abuse. • The quality standard makes explicit that statements on training are not usually described in the quality standard. However, in this instance training is of paramount importance to achieving quality improvement in

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			DVA and should be given direct reference in the statements. A precedent for this has been established by the quality standard on dementia (2010). • Similarly, direct reference should be given to the importance of multi-agency working, again with a precedent established by the quality standard on dementia (2010). Any supporting text in sections on 'what the quality statement means for service providers, healthcare professional and commissioners' should be amended from 'commissioners *may* wish to adopt a multi agency approach' to 'Commissioners *should ensure* they adopt a multi-agency approach'
6	Northumberland Tyne and Wear NHS Foundation Trust	Question 1	1 Partially Agree, *Are there specific 'at risk' groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?* "routine enquiry" of experiencing domestic abuse at the point of assessment should be undertaken where there are any indicators are evident. This data could be gathered within assessment documentation, if yes flagged on health records and shared with other providers of care with permission to do so. To help overcome barriers this should be included in staff training and explained to people of generic question to all How should 'private' be defined within this setting? The person should be seen alone (without a family member or associate present) More than one staff present if deemed necessary .
46	Refuge	Question 1	Yes, with some adjustment and with the exclusion of perpetrator groups. See below for detail.
33	Rotherham Doncaster & South Humber NHS Trust	Question 1	Yes
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 1	Yes – however it needs to be clear to whether it is suggesting that the training can be part of the current safeguarding children/ adult training packages or if it is recommending a separate package. If it is suggesting a separate package of training is this to be single agency or multi-agency?
32	Standing Together against Domestic Violence	Question 1	Yes, overall the proposed standards reflect key areas for quality improvement. We would however recommend that quality standards and training are extended to all healthcare services and that guidelines are not restricted to particular departments.

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			Chelsea and Westminster have adopted a 'whole hospital approach', where all health staff across the hospital have received a general one hour briefing on the dynamics of domestic abuse and how to recognise the signs. Moreover, each area within the hospital has a nominated Domestic Abuse Link, who has received in-depth training on how to appropriately respond to cases of domestic violence. This approach has proved extremely effective and has elicited disclosures from varied departments including a number of high risk cases within physiotherapy and radiology.
22	University of Central Lancashire (UCLAN)	Question 1	Key areas for quality improvement are covered but specific mention needs to be of BME communities, disabled people including those with learning disabilities, gay and transgender people. The needs of these groups are often different to majority heterosexual groups and the quality standard might be well advised to collect information on domestic abuse in these groups and to develop measures for service responses to these groups. See Hester et al's report on the needs and service experiences of marginalised groups: http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/domesticsexualviolencesupportneeds.pdf The service experiences and recommendations for services for BME women can be found in Batsleeer et al's study: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CCcQFjAB&url=http%3A%2F%2Fe-space.mmu.ac.uk%2Fe-space%2Fbitstream%2F2173%2F74953%2F1%2F978-0-954155-01-8.pdf&ei=mTqeVb2_HKXe7AaXw5zwBQ&usg=AFQjCNGnBbzGDLGERip-KgomK7HP-CLMXQ Disability and domestic abuse: Thiara, R.K., Hague, G and Mullender, A. (2011) 'Losing out on both counts: disabled women and domestic violence' *Disability and Society* pages 757-771: http://www.tandfonline.com/doi/abs/10.1080/09687599.2011.602867?src=recsys#.VZ-SOvlViko
42	Women's Aid	Question 1	We welcome the quality standard and the key areas for improvement identified by NICE. Women's Aid is currently developing a new model of response to domestic abuse throughout the community which is based on survivors' needs and strengths. One of the underlying principles of this model is that every point of interaction with a survivor of domestic abuse is an opportunity for intervention and so we warmly welcome the development of these quality standards. Through the development of our new model, Change that Lasts, and consultations with survivors they identified health professionals as key to being able to disclose domestic abuse and seek support. We would advise the consideration that a Quality Standard is developed around the recognition of abuse within GP practices. We know that for many survivors their GP may be the only service they access on their own and a professional they can trust so it is vital that they are able to listen to disclosures and signpost effectively. Furthermore, we would also recommend the development of a Quality Standard on information sharing between

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			different agencies. Although we recognise the need for confidential data to be treated appropriately and safely - learnings from Domestic Homicide Reviews has shown that information sharing is a key area that needs improving through all agencies including healthcare - https://www.gov.uk/government/publications/domestic-homicide-review-lessons-learned
39	AVA (Against Violence and Abuse)	Question 2	It would be possible to collect data if systems and structures were put in place. There are examples of routine enquiry being used and recorded in the health context - for example within the Barking, Havering and Redbridge University Hospital Trust midwives were trained in routine enquiry and the data was collected on the question being asked and ensuring the patient was alone. Similarly, there has been a rise of locating IDVAs within hospital contexts. If commissioners consider putting data collection on domestic violence within contract monitoring it could potentially make it easier to collect data. There would need to be a joined up response to this - thus, the Health and Well-being Board and Clinical Commissioning Groups should be looking at working with the NHS to develop strategy to enable data collection. There should also be links made with domestic violence / community safety at the local authority level so that health and the criminal justice system are properly linked and also to enable a joined up response. This may help further with data collection - in particular whether services are referring women in to the MARAC or to specialist services.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 2	**If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?** The data in the format being requested would be problematic across different organisations unless a standardised template is used and this would be difficult to achieve. Data would also need to be anonymised for this purpose. It would also be important to include safeguarding responses within the data collection.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 2	Data collected routinely for statements 2 and 3 but systems need to be developed for other statements A DV & A policy that states all discussions around DV&A need to be record (as current CMFT policy) would not necessarily make it easy to monitor numbers of discussions or referrals for standard risk victims/survivors. We are only able to monitor numbers of high risk referrals within community as these are the only referrals that come through the Safeguarding Team. Attaining a true picture of referrals would require a central point for all referrals to come through to a central point. Multi-agency work that takes account of the vital role of the NHS in a victim escape process and embedding DV&A within the wider determinants of public health
24	Durham County Council	Question 2	Unable to comment on the collection of A & E and maternity data.

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			Within social care systems assessments are not routinely recorded if there were no onward referrals made, however systems exist to capture this information and would be possible to be routinely recorded following a request for practitioners to capture this information. If an individual disclosed domestic abuse, this would be consistently recorded and held in an existing database. Proportion of reported cases of domestic abuse which are referred to specialist services – is this 'reported' in terms of to the police or to any agency, i.e. a discloser? This is not clear, therefore we are unable to comment. Number of referrals to specialist support services is routinely recorded as is numbers of cases of domestic violence reported to the Police. The numbers of perpetrators referred to specialist support service is consistently recorded by the support service. However the number of people known to perpetrate domestic abuse would only be consistently recorded by the police. It would be difficult to define and record against 'known to perpetrate domestic abuse' without a criminal conviction or a personal statement from the individual to that affect, i.e. a self referral for support.
50	Hampshire Domestic Abuse Steering Group	Question 2	*If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?* • Many services don't currently collect any DA data so these would need to be routinely established before this becomes a realistic prospect. Data requirements and recording needs to be specifically set out so that there is consistency in what is collected and therefore measurable. • Local data collection needs to be based on a national standard. • Define what you want and how you want it collected
47	Institute of Health Visiting	Question 2	Routine collection may be burdensome for organisations; and many victims will not disclose. There is a significant risk of under-reporting. There is however, a role for audit of practice, against the set of quality statements. If victims choose not to disclose, routine enquiry provides them with the knowledge that there are professionals 'out there' who are willing to, and can, help. We thus support routine, safe enquiry.
14	Leeway Domestic Violence and Abuse Services	Question 2	Providing that staff were adequately trained in the process, yes it would be possible.
45	Mid Essex Hospital (NHS) Services Trust	Question 2	From considerable experience, although the subject of data collection sounds as if it should be relatively simple, it is in fact a situation where unless a considerable investment is made in IT to bring in a system which allows simple inputting of information which links to the IT system of the organisation involved and allows data to be pulled out

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			across a range of different factors, then any form of data collection and submission becomes difficult and complex for practitioners. DVA and other abuse information must link directly to the individual's records to minimise the risk of DVA not being recognised and ongoing situations not being monitored. Flags and markers showing potential DVA and screening questions are essential to staff working with people experiencing or perpetrating DVA and to allow information to be highlighted and drawn out for national and local data collection. Most health and social care organisations have different IT systems for recording cases and within those there are a myriad of ways that issues such as DVA are recorded. Many do not even have flags for DVA or other abuse types and rely on staff reading the notes before seeing a patient / service user in order to see whether there are previous issues. This may be manageable in non-acute services such as mental health, social care, maternity and substance abuse, but not within a busy GP or ED service, so flags and clear identification of previous victims and perpetrators is essential. Under the current austerity measures it may not be possible for IT systems to be developed in isolation by individual trusts and organisations so although recording and recalling information is not difficult in theory, in practice it is a significant challenge to ensure robust and consistent data collection across all organisations and then effective reporting back. One of the problems in previous data collection processes has been the continuously changing parameters and reporting requirements from central government which has affected the abilities of organisations to produce consistent and meaningful data. Therefore whatever the data collection requirements are, they must be future proofed against constant amendments and changes in process. In line with this, local and national requirements must also be aligned to ensure that they allow effective data collection and analysis both at a local and national levels. If all the concerns above were addressed, then it is entirely possible to put in place a system whereby practitioners can record their concerns, the actions taken and outcomes in a pragmatic and nationally accepted way. However each part of the recording process must have a benefit to the practitioner in order for recording to be carried out consistently and effectively. In QS4 & 5 here is a measure relating to ensuring the provision of specialist services to support victims and abusers of DVA. This is not a measure for this set of Quality Standards. This is a fact which the health sector on its own cannot fully influence. Specialist resources for DVA and other crime types sits with the Police and Crime Commissioners for each area and therefore it is not a measure for the health commissioners and providers to be judged on in isolation. It needs to be clearly outlined that this is a multiagency responsibility and may sit better in an

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			additional QS relating to integrated services and the multiagency approach.
34	NIHR CLAHRC North Thames	Question 2	***Question 2: If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?*** ***General comments on data collection*** • In theory, the measures of data collection are appropriate, but the systems and structures that would facilitate this are not in place. • Strategies and local plans for DVA would need to be developed, with formal, standardised process for data collection. Without this it will be difficult to assess performance on the proposed quality measures. Moreover, data would have to be collected jointly, facilitated by integrated commissioning. • An overarching issue in the draft quality standard is that training in how to safely record DVA has not been identified as a priority. Without this, there will be issues in data collection and health professionals could put the safety of their patients at risk. ***Statement specific comments on data collection*** *Statement 1. People presenting to A&E departments with indicators of possible domestic violence or abuse have a private one-to-one discussion.* - Training in how to identify the indicators of possible abuse and how to safely enquire about DVA is key to collecting accurate data. *Statement 2. Women presenting to maternity services with indicators of possible domestic violence or abuse have a private one-to-one discussion.* - Enquiry about DVA is already routine in maternity services with limited evidence of efficacy (Mezey, Bacchus, Haworth, & Bewley, 2003). As with Statement 1, training is vital to ensure that health professionals working in maternity services are able to identify, enquire and record information about DVA. *Statement 3. People who disclose domestic violence or abuse have an assessment of their immediate safety.* - Disclosure of DVA is inconsistently recorded and requires additional training for health professionals and standardised processes across health settings and partnering organisations. - There is no validated process for health professionals to assess immediate safety. The full Domestic Abuse,

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			Stalking and Honour Based Violence Risk Assessment Checklist (DASH-RIC) is inappropriate for health professionals to complete due to its length. - The approach taken in the Identification and Referral to Improve Safety (IRIS) model for primary care (Feder et al., 2011) involves GPs carrying out simple questioning about the immediate safety of patients to return home and the safety of children in the home. *Statement 4. People experiencing domestic violence or abuse are offered a referral to specialist support services.* - Reported cases of DVA are calculated using British Crime Survey data. Using this as a denominator would necessitate a joined up approach to data collection across agencies, which should be emphasised more strongly throughout the quality standard. *Statement 5. People perpetrating domestic violence or abuse are offered a referral to specialist support services.* - There is limited data available on the number of people known to perpetrate domestic violence. If this data is to be drawn from the British Crime Survey this would, again, require an integrated pathway of identification and support. - Training is needed for health professionals in how to identify and refer perpetrators for support (Williamson et al., 2014).
43	North Essex Partnership (NHS) Foundation Trust	Question 2	From considerable experience, although the subject of data collection sounds as if it should be relatively simple, it is in fact a situation where unless a considerable investment is made in IT to bring in a system which allows simple inputting of information which links to the IT system of the organisation involved and allows data to be pulled out across a range of different factors, then any form of data collection and submission becomes difficult and complex for practitioners. DVA and other abuse information must link directly to the individual's records to minimise the risk of DVA not being recognised and ongoing situations not being monitored. Flags and markers showing potential DVA and screening questions are essential to staff working with people experiencing or perpetrating DVA and to allow information to be highlighted and drawn out for national and local data collection. Most health and social care organisations have different IT systems for recording cases and within those there are a myriad of ways that issues such as DVA are recorded. Many do not even have flags for DVA or other abuse types and rely on staff reading the notes before seeing a patient / service user in order to see whether there are previous issues. This may be manageable in non-acute services such as mental health, social care, maternity and substance abuse, but not within a busy GP or ED service, so flags and clear identification of previous victims and perpetrators is essential. Under the current austerity measures it may not be possible for IT systems to be developed in isolation by individual

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			trusts and organisations so although recording and recalling information is not difficult in theory, in practice it is a significant challenge to ensure robust and consistent data collection across all organisations and then effective reporting back. One of the problems in previous data collection processes has been the continuously changing parameters and reporting requirements from central government which has affected the abilities of organisations to produce consistent and meaningful data. Therefore whatever the data collection requirements are, they must be future proofed against constant amendments and changes in process. In line with this, local and national requirements must also be aligned to ensure that they allow effective data collection and analysis both at a local and national levels. If all the concerns above were addressed, then it is entirely possible to put in place a system whereby practitioners can record their concerns, the actions taken and outcomes in a pragmatic and nationally accepted way. However each part of the recording process must have a benefit to the practitioner in order for recording to be carried out consistently and effectively. In QS4 & 5 here is a measure relating to ensuring the provision of specialist services to support victims and abusers of DVA. This is not a measure for this set of Quality Standards. This is a fact which the health sector on its own cannot fully influence. Specialist resources for DVA and other crime types sits with the Police and Crime Commissioners for each area and therefore it is not a measure for the health commissioners and providers to be judged on in isolation. It needs to be clearly outlined that this is a multiagency responsibility and may sit better in an additional QS relating to integrated services and the multiagency approach.
7	Public Health England	Question 2	Maternity services have been collecting information for a while. E.G. use of the Green File – given that these standards have effectively been in existence within maternity services for some years, they can rarely provide the data. Commissioners should be able to set penalties against such infringements.
46	Refuge	Question 2	Yes
33	Rotherham Doncaster & South Humber NHS Trust	Question 2	Yes – however there is great varience in systems across the health and socal care landscape which would offer up challenges. Additional challenges would be information on domestic violence is already universally reported on.
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 2	Data can be collected – however within our Trust this would have to be integrated into RiO.
32	Standing Together against Domestic Violence	Question 2	The proposed quality measures and related processes are appropriate for each statement. Data collection is critical to determining the impact of any intervention including the capacity to identify good practice and areas for improvement. There are challenges, however, ensuring departments within trusts capture comparable

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			data and have appropriate methods by which to record information. Hospitals do not always have a common language around data or a shared system in which to record it. Assuming the systems being used have the functionality to record whether the question has been asked / a disclosure has been made, data collection in settings where routine enquiry is undertaken should be relatively simple to collect. A greater challenge arises in capturing data in those departments where opportune enquiry is undertaken. To ensure that the data collected reflects the proportion of patients presenting with indicators of domestic abuse who are being asked the question, the information should be split in response to the following questions: • Does the patient present with indicators of domestic abuse? • Was the question asked? • Was a disclosure made? What referrals were offered/ accepted?
22	University of Central Lancashire (UCLAN)	Question 2	A&E are extremely busy places where priority is given to people with life threatening presentations. It is also difficult to recruit health professionals to A&E and asking about domestic abuse and recording this may be seen as an additional task of low priority in the context of A&E departments. Nevertheless, A&E is an important site of intervention as it offers a non-stigmatising opportunity to support people experiencing domestic violence. A PhD study conducted in A&E departments re: domestic violence also found that health professionals were unsure how to intervene and what to do with the information if a patient disclosed domestic abuse. Further this study also found that where victims did not have children, A& E staff did not see this as a safeguarding issue (Tokode, 2012). Whilst all health care professionals require adequate training re: domestic abuse, it may be more practical to also have a specialist domestic abuse nurse practitioner or a domestic abuse worker (e.g. IDVA or refuge worker) located within A&E. Universal screening for domestic abuse may reach a wider population of victims than actuarial/risk based screening.
22	University of Central Lancashire (UCLAN)	Question 2	There is no measure for evidence of local arrangements to ensure health care professionals are trained to recognise domestic abuse. Further, one would also need to assess the impact of such training. Research is equivocal about the impact of such training six to twelve months after the training.
42	Women's Aid	Question 2	Yes
25	Cheshire West and Chester Council	Question 2(a)	Yes the data collection would be possible in our experience. Our hospital currently reports on some of the data discussed.
25	Cheshire West and	Question	Current NHS ICT systems and structures would need significant revision to enable the required data to be collected.

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	Chester Council	2(b)	
39	AVA (Against Violence and Abuse)	Question 3	Consultation undertaken by AVA found 46% of practitioners coming into contact with survivors of abuse lacked confidence in asking victims about domestic abuse and 54% lacked confidence in responding effectively to disclosures of abuse. This lack of confidence may affect the successful implementation of the quality standards as practitioners do not want to ask and do not feel confident in responding. This suggests training to ensure practitioners have the confidence to ask and respond to domestic violence and abuse will help over come barriers to the successful implementation of the quality standards.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 3	**For each quality statement what do you think could be done to support improvement and help overcome barriers?** Mandatory on-going training for all health care staff regarding DV is essential. It is also important to display written information for both survivors and perpetrators attending organisations who may wish to speak to someone. Although case-based DV enquiry that is being proposed in this draft quality standard can be effective if staff are well trained in all the indicators of DV there is a case for routine enquiry as this gives patients 'permission' to talk about this subject, avoids patients feeling stereotyped and raises awareness both for survivors (that they are not alone) and for those who have not personally experienced DV (that this is something that affects many people and what services are available). Details of local services need to be available for staff and patients, that contact details and referral pathways to these services are clear and up-to-date. Forging close links with DV services as well as standardised referral forms and pathways to DV services ease completion and referrals. Local services should be reviewed to check that vulnerable groups are catered for
31	British Medical Association	Question 3	We believe that in order to support improvement and help overcome barriers adequate training to increase awareness must be provided to health and social care professionals, schools and anyone who works with potential victims. Also, there is a need to provide high profile information in public places about domestic violence, how common it is and where to seek help. Multidisciplinary training should also be provided so that each professional can understand the difficulties that a victim needs to overcome.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 3	Overcome barriers 1- 4 achievable within current health S5 needs multi agency stakeholder involvement. Clear policies and protocols in place. Investment in staff training.
25	Cheshire West and Chester Council	Question 3	Agree that a private one to one discussion should take place.

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3	City Health Care Partnership CIC	Question 3	**CHCP CIC Response:** we have identified the following enablers: • Provision of training to all service user facing staff, with advanced training for areas of greatest need/those caring for service users who are at highest risk. • The provision of dedicated clinical supervision and mentorship, (for example similar to that offered by safeguarding practitioners to staff who work with children), whereby staff involved in routine enquiry and the care of people who are victims of domestic violence can discuss anonymised case studies, gain support etc. from a senior clinician with a special interest and advance training in domestic violence. • The development of clear, easily navigated and rapid referral/access to pathways of care. For example a well-advertised single point of contact for referring victims into the support they need. • Development of a managed network for domestic violence at each CCG level to ensure a multi-agency and multi-professional approach to the development of services and pathways. This could form part of the local safeguarding committee's role?? • More marketing and promotion to raise awareness for both victims and perpetrators of domestic violence at both a city and national level. E.g. building on the success of Childline and other national initiatives.
24	Durham County Council	Question 3	A continuous cycle of training and development for health and social care practitioners in relation to domestic abuse would ensure that staff are kept up to date on recent developments and the subject is revisited on a regular basis. Barriers exist around raising awareness of referrals pathways and support services that are in place in an area. This highlights the importance of a strong local partnership to ensure that information is shared as widely as possible and that key messages are agreed and rolled out by all. More support should be in place to tackle perpetrators of domestic abuse. In County Durham this is reliant on perpetrator programmes, which often only works with individuals when they are ready to change. Further research is required on alternative options for working with perpetrators. Recent research is beginning to examine the different types of intimate partner violence and drawing distinctions between 'conflict-initiated violence' and 'control-initiated' violence (Wangman, 2011). The distinct differences between certain types of violence would warrant a different approach when working with perpetrators and more work should be done to investigate this.
47	Institute of Health Visiting	Question 3	Training is key (see above), as is knowledge of provision at a local level. We heard anecdotal evidence when delivering the iHV training that local services were subject to budget cuts and loss of provision (during 2013-2014).
14	Leeway Domestic Violence and Abuse	Question 3	In our experience working with local hospitals in Norfolk the biggest barriers are staff not feeling confident asking to speak to potential victims on their own, not knowing how to phrase the question & what to do with the answer. This

ID	Stakeholder	Statement number	Comments[3]
	Services		can be overcome with staff training briefings & protocols.
45	Mid Essex Hospital (NHS) Services Trust	Question 3	As previously outlined, by only including A&E and maternity departments in the Quality Statements there is an inbuilt barrier for staff within those organisations. Maternity departments are already required to undertake routine questioning so for them it will be more to do with the recording and recall of the information. Additionally at the current time they are required to undertake routine questioning and the QS takes this down to only when DVA is suspected. Why lower the requirement which is currently in place? Without the other parts of the health system being part of the QS there is the potential for A&E staff to feel that they are expected to carry the burden alone and this is not a position from which to build a positive and engaged workforce. If all aspects of the health service are included then the resistance and barriers become lessened as all practitioners and support staff will have expectations placed on them in line with their training and contact with patients and service users. There will be greater buy-in from all organisations as training can be consistent across the areas and the requirements are the same with every agency being measured in the same way and supported to achieve the same aims. If the basic question set becomes more 'abuse' focused then staff will also see a wider benefit than the focus on DVA, although that is where the Guideline obviously concentrates.
34	NIHR CLAHRC North Thames	Question 3	***Question 3: For each quality statement what do you think could be done to support improvement and help overcome barriers?*** **Statement 1.** People presenting to A&E departments with indicators of possible domestic violence or abuse have a private one-to-one discussion - Training for all health professionals in A&E departments in how to identify the signs of DVA, safely enquire with patients and appropriately record in patient records. - Dedicated space for private discussions to take place **Statement 2**. Women presenting to maternity services with indicators of possible domestic violence or abuse have a private one-to-one discussion. - Improve the implementation of routine enquiry by providing enhanced training, and ensuring the resources, staff support and policies are in place that allow staff to enquire about DVA safely and confidentially (Mezey et al., 2003). **Statement 3.** People who disclose domestic violence or abuse have an assessment of their immediate safety.

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			- Training for all health professionals in how to simply assess immediate safety, and where to refer patients who may require a full assessment if they are considered high risk. **Statement 4.** People experiencing domestic violence or abuse are offered a referral to specialist support services. - Integrated pathways of support need to be commissioned, which give health professionals a direct point of contact to whom they can refer victims of DVA. - Multiple opportunities of referral should be offered. A patient's GP should be informed about the identification of DVA so they can follow up if the victim has not accepted a referral in that instance, to provide continuity of care more broadly. **Statement 5.** People perpetrating domestic violence or abuse are offered a referral to specialist support services. - Training for health professionals in how to identify, record and refer perpetrators of domestic violence. Continued support of improvement of the service (including overcoming specific barriers in local sites) will be aided by joint working between multiple agencies, including data collection and sharing so that it can be ensured that existing DVA research (see IRIS study published in the Lancet) is translated into practice successfully (i.e. clinically and cost effectively). An example of this is the current work of the North Thames CLAHRC evaluating implementation of a clinical DVA training, support and referral programme (IRIS) in 180 GP practices in northeast London.
43	North Essex Partnership (NHS) Foundation Trust	Question 3	As previously outlined, by only including A&E and maternity departments in the Quality Statements there is an inbuilt barrier for staff within those organisations. Maternity departments are already required to undertake routine questioning so for them it will be more to do with the recording and recall of the information. Additionally at the current time they are required to undertake routine questioning and the QS takes this down to only when DVA is suspected. Why lower the requirement which is currently in place? Without the other parts of the health system being part of the QS there is the potential for A&E staff to feel that they are expected to carry the burden alone and this is not a position from which to build a positive and engaged workforce. If all aspects of the health service are included then the resistance and barriers become lessened as all practitioners and support staff will have expectations placed on them in line with their training and contact with patients and service users. There will be greater buy-in from all organisations as training can be consistent across the areas and the requirements are the same with every agency being measured in the same way and supported to achieve the same aims. If the basic question set becomes more 'abuse' focused then staff will also see a wider benefit than the focus on DVA, although that is where the Guideline obviously concentrates.

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7	Public Health England	Question 3	It is important that the quality standards are explicit about the safety of women who choose to disclose their experiences of DV. These should be referenced through staff supervision, identification of "Training Champions", performance related targets both individual and collective, relationships with specialists and through good leadership across organisations
30	R.I.S.E.	Question 3	To recognise the barriers and support improvements we may want to know not just how many DVA victims have been identified and how many referrals offered but also how many referrals actually made. The patient has the right to decline support but if for an overwhelmingly majority of the identified DVA victims referrals have not been made, the question would then be about the quality of the questions asked and services introduced. Also for a victim who has disclosed the abuse and accepted the offer of a referral to DVA service/support and then not completing a referral would be a great failure on the professional's behalf.
33	Rotherham Doncaster & South Humber NHS Trust	Question 3	Comprehensive universal benchmarking tools.
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 3	Due to the increased amount of disclosure from individuals and the increasing demand on MARAC meetings/ request for service into social care consideration needs to be given to the statement immediate safety and how this can be achieved. Also I feel that the assessment of their immediate safety also has to give consideration to the safety of their children (if they have children) due to the increase in filicide/ lessons from serious case reviews etc. Consideration also needs to be made in relation to mental capacity – if the discloses the domestic violence but does not want to press charges/ give consent to share information.
32	Standing Together against Domestic Violence	Question 3	Data collection and training are essential when monitoring progress, identifying and addressing any issues in the response provided. Training should be reviewed and updated regularly in accordance with national evidence and best practice. Specialist training looking at the intersection of domestic abuse and equality issues should also feature in the training. This should include the specific experiences of LGBT people, BME, disabled and older women and the multiple barriers they may face when accessing support.
22	University of Central Lancashire (UCLAN)	Question 3	Specialist domestic abuse nurse practitioner, IDVA or specialist domestic abuse worker to be located in A&E departments
42	Women's Aid	Question 3	Specialist training in domestic abuse awareness, including discussions of coercive and controlling behaviour which is a new criminal offence and will hopefully come into force later in 2015.
25	Cheshire West and Chester Council	Question 3(a)	A dedicated and experienced DA team within an organisation to lead and support staff on the DA response (multi agency) across the organisation, should be in place
25	Cheshire West and	Question	Agree women presenting to maternity services should have a one to one discussion about possible domestic violence

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	Chester Council	3(b)	or abuse.
39	AVA (Against Violence and Abuse)	Question 4	It is disappointing that no reference is made to GP surgeries given they are the most utilised resources by victims and perpetrators of dv and also that we have strong evidence for their role in improving disclosure and referrals to specialist services (IRIS).
39	AVA (Against Violence and Abuse)	Question 4	We would also recommend that drug and alcohol and mental health services should be reflected in the list of services which encounter high numbers of domestic violence victims given the extensive evidence of associations (Khalifeh et al 2015, Trevillion et al 2013, Natcen 2013, Humphreys 2005) which is reflected in NICE recommendations. Given that we know women presenting with substance use or mental health issues are highly likely to be experiencing or to have experienced domestic or sexual violence (Rees 2011) , there is also a need to ensure professionals have proper training and understanding of the interconnections between the three areas so that staff are properly able to support survivors in this context.
39	AVA (Against Violence and Abuse)	Question 4	School nurses are often a key person that young people choose to disclose to, and health visitors are in a unique position to identify warning signs and facilitate disclosures as they are entering the victim's home.
39	AVA (Against Violence and Abuse)	Question 4	Sexual violence is included in the government definition of domestic violence. 45% of rapes have been committed by a person's current partner (British Crime Survey 2001). Indicators of sexual ill health may also suggest abuse and violence within a relationship and therefore sexual health services should be on the list.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 4	**For draft quality statements 1 and 2: Do these services reflect those who would mainly encounter people with possible indicators of domestic violence or abuse? If not what other services should be included?** Although the draft quality standard addresses the key areas of maternity and emergency medicine services, it does not include additional key services such as sexual health, sexual assault services, reproductive care, mental health, substance misuse services fracture clinic and children's and vulnerable adults' services. Data from Chelsea and Westminster has shown that more survivors present via sexual health/HIV services than via emergency medicine and data from an anonymous patient survey in women attending St Thomas hospital in 2008 showed nearly twice the prevalence of a lifetime experience of DV since the age of 16 in these women compared with national data (47% [1] vs. 28% [2]). Similar high rates of DV are seen in HIV+ve women with 52% affected in a recent study in East London [3]. We would support routine enquiry in these areas as per NICE 2014 guidelines[4]. 1 DV in a GUM setting-an anonymous prevalence study in women Loke et al IJSA 2008;19: 747-51 2 Office for National Statistics 2015 Chapter 4:Violent Crime and Sexual Offences www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime-and-sexual-offences--2013-14/

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			3 IPV in women living with HIV attending an inner city clinic in the UK: prevalence and associated factors **Dhairyawan, R. et al** *HIV Medicine* (2013), **14**, 303–310 4 NICE guidelines [PH50] 2014. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively www.nice.org.uk/guidance/ph50
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 4	Consider Community Health Visitors and GP, maternity, gynaecology, sexual assault referral centres. Other emergency services such as eye and dental.
3	City Health Care Partnership CIC	Question 4	**CHCP CIC Response:** As identified at question 1, we do not feel that the two service areas identified are the only ones that would mainly encounter people with indicators of abuse. We feel other unplanned care services, health visitors and school nurses may also identify significant numbers of victims. District Nurses and Long Term conditions teams may identify elder abuse; staff delivering mental health or learning disability services may also identify a significant number of victims. For example people with a disability are at greater risk, statistically of domestic violence or abuse, than the general public. Therefore we feel training should be extended to all, and also sensitive use of routine enquiry.
24	Durham County Council	Question 4	• GP's • Mental health services • Sexual health services • Substance misuse services
50	Hampshire Domestic Abuse Steering Group	Question 4	*For draft quality statements 1 and 2: Do these services reflect those who would mainly encounter people with possible indicators of domestic violence or abuse? If not what other services should be included?* GPs, dentists, all other primary care settings
14	Leeway Domestic Violence and Abuse Services	Question 4	These are the main services where they would encounter potential victims of abuse, however in Norfolk we had a large number of cases in orthopaedics. It is also worth considering emergency dental care services.
34	NIHR CLAHRC North Thames	Question 4	***Question 4: For draft quality statements 1 and 2: Do these services reflect those who would mainly encounter people with possible indicators of domestic violence or abuse? If not what other services should be included?*** These services do not reflect the full range of health settings that would mainly encounter people with possible indicators of DVA. Indeed other health settings (see below) are very likely to have a higher prevalence of women presenting to them who are affected by DVA (e.g. substance misuse).

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			1 in 4 women in the UK will be affected by DVA in their lifetime (Garcia-Moreno et al, 2013). There are a wide range of negative health consequences for victims of domestic violence (Valpied & Hegarty, 2015). This means that all health professionals will routinely encounter people with possible indicators of domestic violence. As well as emergency and maternity services, there is strong evidence demonstrating a high prevalence of domestic violence among users of the following services: - Substance misuse (Humphreys and Regan, 2005) - Mental health (Oram, Trevillion, Feder, & Howard, 2013; Trevillion, Oram, Feder, & Howard, 2012) - Sexual health (Coker, 2007) - Primary care (Richardson et al., 2002) Statements relating to these services should also be included in the quality standard.
43	North Essex Partnership (NHS) Foundation Trust	Question 4	Why are the statements limited to Acute Trusts in the form of Emergency departments (A&E) and maternity only? We know that most victims and abusers are most likely to have interactions with their local GP practice and often with their mental health and associated health providers. Why are these not included in this document at all. Surely this Quality Statement should not be restricted to the acute Trusts, but should apply to all patients and service users attending a medical appointment whether that is at an ED, GP or mental health facility Statement 1&2 should be merged to cover all health providers overseen through the CCG commissioning process and also GPs. In this way people experiencing or perpetrating abuse will be considered at any stage of the health continuum it will not be only one relatively small aspect being held to account. Additionally by concentrating on A&E and maternity you are continuing the stereotype that DVA really only affects women. We know that women suffer more severe violence from men than the other way round, but coercive control, physiological and emotional abuse can affect men equally and they are more likely to attend a GP practice, mental health or substance abuse provider than A&E. Older people, same sex relationships and abuse of people with care and support needs are more likely to be reported to a GP or district nurse than either of the two locations subject to the statements so again the requirement to ensure there are trained staff, an understanding of DVA and the ability to offer support and guidance must not be limited to the Acute and maternity sectors. Reviews of the DHR carried out in Essex indicate that GP, community and mental health services have significant

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			areas for improvement to ensure that all people experiencing or perpetrating DVA are given the opportunity to disclose abuse and be supported in their situation. As an additional point, it might be more appropriate in this era of growing understanding of a wider range of abuses to have a mandatory one to one conversation with all patients and service users as part of the initial consultation to cover all types of abuse. This would still only require a few questions
7	Public Health England	Question 4	Perhaps give examples of what is meant by "people" in statement 1, This could include people with a disability. Women who are in "same sex relationships" etc. Could add the word "confidential" here also.
30	R.I.S.E.	Question 4	Other services: sexual health clinics (see your list of DV indicators) and GPs.
33	Rotherham Doncaster & South Humber NHS Trust	Question 4	Yes
10	Royal College of Obstetricians & Gynaecologists	Question 4	For question 4: GPs, psychiatric services, Sexual and Reproductive Health Services should be included
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 4	Needs to consider mental health/ substance misuse/ learning disability services and universal services (health visiting/ school nursing/ Family Nurse Partnership and G.P's), also education when looking at areas/ departments where domestic violence may be disclosed.
11	The Royal College of Midwives	Question 4	Yes - most victims of abuse would use A& E or maternity but other wards in the hospital should not be disregarded.
22	University of Central Lancashire (UCLAN)	Question 4	Mental health services should also be included, given the evidence of the impact of domestic abuse on people experiencing it.
42	Women's Aid	Question 4	As mentioned above we would also recommend including GP practices. It may also be worth considering the inclusion of sexual and reproductive health services.
25	Cheshire West and Chester Council	Question 4(a)	Yes the AED and Maternity services are by far the key clinical areas whereby we will see victims of DA. But can be corporate too. (important to recognise staff experiencing too given health services employ so many female members of staff)
25	Cheshire West and Chester Council	Question 4(b)	It would be important to include Sexual Health Services
39	AVA (Against Violence and Abuse)	Question 5	Domestic violence and abuse cuts across all sections of society. Disclosure is never easy for the victim or survivor , and it is important that all health and social care professionals ensure they take an holistic and survivor centred approach that increases the likelihood of someone feeling confident to disclose abuse and seek help at the point

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			where they feel ready to do so. 16-24 year olds are the highest risk age group and staff should be trained to recognise signs of abuse and how to safely and sensitively ask (this may be different than for adult women). Young people will often have multiple needs that impact on their safety and risk and may also face multiple forms of abuse as well as domestic violence (for example, sexual exploitation, gang based abuse, sexual abuse, abuse that takes place online) and practitioners must understand these issues, the links between them and the appropriate referral pathways . Recent research (Barter et al, 2015) has also shown that young people with older partners or who are in same sex relationships are also at higher risk.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 5	**For draft quality statements 1 and 2: Are there specific 'at risk' groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?** Other specifically at risk groups that should be considered include, • Young people aged 16-25, • LGBT • Sex workers • Trafficked persons • Substance misuse populations • Individuals with language barriers • Homeless populations • Migrants/ refugee status • History of social care involvement • Learning difficulties or disability • Pregnant women • Mental health issues In addition the SPECSS indicators used by the Metropolitan Police acronym may be useful; separation, pregnancy, escalation, community isolation/children, stalking, sexual violence and the person's own fear. However it is essential that all persons, regardless of risk group or indicators, are given the opportunity to disclose DV and again why we support routine enquiry for DV.
31	British Medical	Question 5	We are reluctant to identify specific "at risk" groups. The statistics quoted at the introduction of the consultation paper

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	Association		show that domestic violence and abuse is a common and wide spread problem. If health professionals are steered towards “at risk” groups, there is the danger that they might miss people who fall outside certain indicators. In general, we believe health professionals should have a low threshold for asking patients about domestic violence and abuse and should receive training in how to do so in a sensitive way.
31	British Medical Association	Question 5	We believe that ‘unexplained injury’ should be added to the list of symptoms or conditions that indicate possible domestic violence and abuse.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 5	Consider Community Health Visitors and GP, maternity, gynaecology, sexual assault referral centres. Other emergency services such as eye and dental.
3	City Health Care Partnership CIC	Question 5	**CHCP CIC Response:** Whilst we recognise and agree with the list of indicators, because these are so very wide, and in order to prevent stereotyping of those at risk, or creating gaps in provision, i.e. missing those that don’t have any of the indicators; we have identified the need for routine enquiry, whereby people are opportunistically asked, in a one to one consultation in a private setting. For example, all people registering with a new GP. For those at greatest risk, for example pregnant women, we feel routine enquiry should be a mandatory requirement. What we do recognise is the need for greater education about risk factors e.g. pregnancy and indicators e.g. a woman who is always accompanied by a partner who speaks for her. For example, so that staff who may see a service user over a number of years (and for whom it would not be appropriate to ask about domestic violence at each visit or intervention) can identify patterns in ill health that could indicate domestic violence and so sensitively explore rationale for ill health including considering the presence of domestic violence. This could be relevant for the GP, health visitor, and learning disability nurse etc. who may see the same service user for many years.
24	Durham County Council	Question 5	Domestic Homicide reviews conducted within County Durham have found that there is a specific risk to women over the age of 40. It is well evidenced that experiencing domestic abuse along with mental health issues and substance misuse issue dramatically increases the risk to the individual. It would be helpful to highlight to practitioners which indicators identify a possible escalation of risk, i.e. evidence of the ‘toxic trio’ above, recent separation, pregnancy or signs of sexual assault.
50	Hampshire Domestic Abuse Steering Group	Question 5	*For draft quality statements 1 and 2: Are there specific ‘at risk’ groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?* People with ante- and post-natal depressions
14	Leeway Domestic	Question 5	Patients with any of the listed indicators could be at risk. We would recommend making ‘asking the question’ as

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	Violence and Abuse Services		routine enquiry of all patients as there is less likelihood of a patient slipping through the net.
45	Mid Essex Hospital (NHS) Services Trust	Question 5	Please also see previous comments. Whether the QS are extended as recommended above or remain only a responsibility for the acute trusts it is difficult to know how expecting staff to memorise a list of indicators and to identify these in a one or two minute triage or assessment would make the process better for victims. Some of the indicators will not be within the scope of the nurse in A&E to discuss sufficiently to identify them as indicators of abuse. Some are typical of the majority of attendees at specific times (alcohol abuse being a prime example) and others would be irrelevant to the reason for attendance. It may be more effective to make it mandatory for all patients / service users to be seen alone at some point during their initial assessment when a more generic type of question can be asked to elicit potential abuse and plans can be put in place to undertake a more detailed assessment on that visit if the initial risk factors indicate an immediate risk of serious harm or death. However if the screening indicates a lower level of risk factors, an appointment for further assessment or offer of referral to a specialist agency can be carried out. By insisting on this one to one part of the assessment it would not raise suspicions about the intentions of the professional on the part of the perpetrator, it would become as normal as the current routine screening in pregnancy which is now an expected part of consultations carried out by midwives with expectant mothers. As importantly it would empower practitioners to remove a third party from the consultation especially where concerns have already been raised, a mandate from the hospital or national authorities can be a powerful tool for staff to assist in effective and safe screening. I would not be in favour of numbers or combinations of different indicators being used as the initial screening tool. Experience from policing is that where this happens people become bound by whether the criteria is met not what actual level of risk is. Where people are asked about abuse it is often questions such as ‘is there anyone who hurts or threatens you, you are scared of, who stops you doing what you want to do or says things that are hurtful or make you feel bad’ which allow people to open up about the key issues in their lives. If the answer to this type of question is ‘yes’ then further questions can be asked to identify the type of abuse, who is perpetrating it, and the general level of risk to the person experiencing it. It then becomes a victim led process not a situation where professionals are trying to second guess what is happening in a persons life.
34	NIHR CLAHRC North	Question 5	***Question 5: For draft quality statements 1 and 2: Are there specific ‘at risk’ groups who should be asked***

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	Thames		***about domestic violence and abuse, for example, people with 7 of 34 certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?*** As detailed in the answer to Question 4, domestic violence is pervasive and has wide ranging negative health consequences. Moreover, there is no typical number or set of signs that may indicate domestic violence. In order to improve identification of domestic violence, health professionals in emergency, maternity, primary care, sexual health, mental health and substance misuse settings should be trained in domestic violence. This will enable them have a low threshold for questioning patients who present with potential indicators of abuse, informed by their clinical judgement and knowledge about domestic violence.
43	North Essex Partnership (NHS) Foundation Trust	Question 5	Please also see previous comments. Whether the QS are extended as recommended above or remain only a responsibility for the acute trusts it is difficult to know how expecting staff to memorise a list of indicators and to identify these in a one or two minute triage or assessment would make the process better for victims. Some of the indicators will not be within the scope of the nurse in A&E to discuss sufficiently to identify them as indicators of abuse. Some are typical of the majority of attendees at specific times (alcohol abuse being a prime example) and others would be irrelevant to the reason for attendance. It may be more effective to make it mandatory for all patients / service users to be seen alone at some point during their initial assessment when a more generic type of question can be asked to elicit potential abuse and plans can be put in place to undertake a more detailed assessment on that visit if the initial risk factors indicate an immediate risk of serious harm or death. However if the screening indicates a lower level of risk factors, an appointment for further assessment or offer of referral to a specialist agency can be carried out. By insisting on this one to one part of the assessment it would not raise suspicions about the intentions of the professional on the part of the perpetrator, it would become as normal as the current routine screening in pregnancy which is now an expected part of consultations carried out by midwives with expectant mothers. As importantly it would empower practitioners to remove a third party from the consultation especially where concerns have already been raised, a mandate from the hospital or national authorities can be a powerful tool for staff to assist in effective and safe screening. I would not be in favour of numbers or combinations of different indicators being used as the initial screening tool. Experience from policing is that where this happens people become bound by whether the criteria is met not what actual level of risk is. Where people are asked about abuse it is often questions such as ‘is there anyone who hurts or

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			threatens you, you are scared of, who stops you doing what you want to do or says things that are hurtful or make you feel bad' which allow people to open up about the key issues in their lives. If the answer to this type of question is 'yes' then further questions can be asked to identify the type of abuse, who is perpetrating it, and the general level of risk to the person experiencing it. It then becomes a victim led process not a situation where professionals are trying to second guess what is happening in a persons life.
6	Northumberland Tyne and Wear NHS Foundation Trust	Question 5	*For draft quality statements 1 and 2: Are there specific 'at risk' groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?* This should be based on indicators in the first instance and then the vulnerabilities.
7	Public Health England	Question 5	Women at risk should include: women with disabilities where abuse could be specifically higher and drug users, however, whist it would be difficult to create an exhaustive list, it will be useful to work on the premise that any woman could be at highest risk of DV so the guidelines should advocate for all women to be asked about experiences of DV routinely and that services should make the asking of such questions part of their "normal" practice (routine assessment).
33	Rotherham Doncaster & South Humber NHS Trust	Question 5	No – should be a universal question to all routinely asked.
52	Royal College of Nursing	Question 5	One of the initial consultation questions relates to who is at risk of domestic abuse and violence. The evidence from a number of sources suggests that we are all at risk of domestic abuse and violence and one's gender, sexual orientation, gender identity, socio-economic circumstances, religion, faith or belief, race or nationality does not exempt individuals from potential risk. Critically, the issue is whether services understand the specific needs of groups with protected characteristics and can respond to them appropriately that is important.
20	Sanctuary Supported Living- Housing Association	Question 5	. Nice should consider people where English is not their first language . People with no recourse to public funds. . Private should mean room where they cannot be overheard which is away from anyone accompanying the patient.
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 5	Needs to consider cultural relationships and disclosure/ thinking about 'forced marriage' and 'honour based violence' For other groups who may be at risk does it need to consider 'same sex relationship' 'transgender' etc?
11	The Royal College of	Question 5	Anyone can be a victim of domestic abuse and not all will present with injuries – Domestic Abuse has no social

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	Midwives		boundaries. It is also important to consider children attending A&E as they may have been caught in the cross fire of domestic abuse between parents
22	University of Central Lancashire (UCLAN)	Question 5	A universal screening approach is likely to 'capture' more relevant people than an actuarial approach and helps to reduce professional bias in who professionals think fits the descriptor of victim or perpetrator.
42	Women's Aid	Question 5	The list of 'at risk' groups identified in the draft quality standard is generally very comprehensive. We would suggest adding women, children and young people and people for whom English is not a first language.
49	Sheffield City Council	Question 5 and 7	Response to questions for consultation: • Targeting – A key risk factor is the 'intrusive other person' which can be indicative of coercive control. I think this issue should be given weight. However I also think that that professional curiosity and professional judgement are key e.g. re. unexplained or unusual injuries and conditions. Asking the question re. why has this young / old / normally healthy person got this condition or injury? • Privacy – I would suggest this needs to be a conversation where the patient feels able to talk freely e.g. they are not overheard by an 'intrusive other person' and / or other patients / staff not involved in the conversation.
25	Cheshire West and Chester Council	Question 5(a)	Difficult to aim DA enquiry just at specific groups because although there are indicators and key clinical areas where we will see victims, DA can impact on anyone and therefore important to raise this point. Routine enquiry in Maternity Services is very important and selective enquiry in AEDs as mentioned above in Q1 should be the way forward
25	Cheshire West and Chester Council	Question 5(b)	Frequent attenders at A & E with unexplained or inconsistent accounts of bruising or displaying excessive stress should be asked about domestic violence and abuse.
39	AVA (Against Violence and Abuse)	Question 6	If someone is deemed as vulnerable this may be an additional reason to see them alone. In the context where someone has a carer with them they may be at risk from their carer, again this may indicate the need to see someone alone. If someone is deemed to lack capacity or understanding then it may be worth considering independent advocates to support them in conversation - for example a mental health advocate or support worker.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 6	**For draft quality statements 1 and 2: Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?** In the majority of cases a discussion should take place one to one with no-one else in the room that is over the age of 18 months. This can be challenging with patients who require additional support be that language translation (where a professional language interpreting service should always be available and offered and family members or friends should not be used for translation) or support with learning difficulties however attempts should always be made to offer a private one-to-one consultation. There are occasionally cases were it may also be appropriate to have more than one staff member present who is also involved in care of that person e.g. sexual offences examiner and

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			chaperoning nurse / ISVA.
31	British Medical Association	Question 6	Whether a discussion should take place on a one-to-one basis - we believe that this should be led by the patient. For example, in cases where the abuser is present, they need to cleverly be removed from the room. However, flexibility should be shown in cases where the patient has brought with them a trusted person, who they might need for moral support while they disclose. Health professionals should be trained to manage such situations, even though this is very difficult and will not always be successful. In cases where an interpreter is needed, the discussion naturally cannot take place on a one-to-one basis.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 6	Private is confidential 1:1 environment with no disruption. In a busy environment e.g. A & E it can be difficult but needs to be a priority as the risk to and safety of the victim can depend on it. Children should not be present.
3	City Health Care Partnership CIC	Question 6	**CHCP CIC Response:** For all inpatient or outpatient/clinic based care, there should always be the opportunity for a one to one intervention and questioning. For example, in our services we always advise partners and carers that the service user/patient will have part of the consultation as a one to one to enable them to discuss any embarrassing symptoms that they might not disclose in front of a partner, parent or carer. This provides the opportunity to raise DV in privacy. The rejection of this by the woman or accompanying person can be an indicator of DV. This could be more difficult if providing care within the service users own home, in which case education should include how this barrier might be overcome. For example by asking other relatives to respect the need for a home visit to again include some time for the nurse/healthcare professional (and potentially a chaperone) to consult with the service user without other family members being in the same room.
24	Durham County Council	Question 6	Unable to comment.
50	Hampshire Domestic Abuse Steering Group	Question 6	*For draft quality statements 1 and 2: Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?* It needs to because we can't assume who is perpetrating the abuse (e.g. HBV, same sex relationships). Exceptions would perhaps be in the case where an interpreter is required (using a professional, not family member or friend) or other professional support.
14	Leeway Domestic Violence and Abuse Services	Question 6	In practice no perpetrators will not let their victim be seen alone & will have numerous reasons why they need to stay. Staff will need appropriate training on how to politely ask them to leave whilst maintaining the safety of the victim & themselves. If the perpetrator refuses to leave staff will need to be able to recognise this as a safety risk & respond accordingly to safeguard the patient.
45	Mid Essex Hospital (NHS) Services Trust	Question 6	The screening must always take place without the friends or relatives of the potential victim. Where the person is a child or adult at risk all organisations should have processes in place to bring in another staff member or volunteer to ensure the welfare of the adult at risk and ensure their welfare needs are managed at that time.

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			Again if abuse screening becomes a routine part of the health pathway and one to one contact is a requirement then families, friends and carers will come to expect this as part of the caring and support pathway.
34	NIHR CLAHRC North Thames	Question 6	***Question 6: For draft quality statements 1 and 2: Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?*** Where possible, discussion on a one-to-one basis should be prioritised. However, there are situations in which this may prove difficult: - Patients who lack capacity In these instances clinicians actions should be informed by the Mental Capacity Act (2005). Where possible, an independent advocate should be sought in order to avoid involving a possible perpetrator in discussions about DVA. - Patients without English as a first language In these situations language services should be accessed, rather than seeking translation through a partner or family member.
43	North Essex Partnership (NHS) Foundation Trust	Question 6	The screening must always take place without the friends or relatives of the potential victim. Where the person is a child or adult at risk all organisations should have processes in place to bring in another staff member or volunteer to ensure the welfare of the adult at risk and ensure their welfare needs are managed at that time. Again if abuse screening becomes a routine part of the health pathway and one to one contact is a requirement then families, friends and carers will come to expect this as part of the caring and support pathway.
6	Northumberland Tyne and Wear NHS Foundation Trust	Question 6	*For draft quality statements 1 and 2: Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?* Down to professional judgement within the assessment, definite seen alone, if two staff deemed proportionate based on risk.
7	Public Health England	Question 6	1:1 meetings should be an essential element of our engagement if we are to achieve a quality outcome. …e.g. in cases where the woman has a LD, the carer could be the abuser.
33	Rotherham Doncaster & South Humber NHS Trust	Question 6	Yes
4	Royal College of Paediatrics and Child	Question 6	We agree with private one-one discussion with suspected abused person. The person undertaking this discussion should be same gender as the suspected abuse (usually female) and near same age. This may enable the

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	Health		suspected abused person to disclose abuse.
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 6	Needs to consider the impact of asking the victim questions in front of the possible perpetrator (this can often occur if asked about Domestic violence in someone's home). Does it need to consider an appropriate adult where necessary? Does it need to consider asking if they would like a chaperone?
11	The Royal College of Midwives	Question 6	It is expected that this discussion would always take place on a one-to-one basis. In Scotland all women regardless of risk receives a letter prior to booking that outlines that at some point in her early antenatal care that she will get private time with a midwife. This has worked in practice, even where abusive partners have attended with them to appointments (all the time) as it's seen as normal practice and nothing special. The process has been successful.
22	University of Central Lancashire (UCLAN)	Question 6	The preferred model should be a 1:1 discussion. Where the person lacks capacity, they should be consulted on who they feel comfortable with. Particular complexities arise when the carer is also the perpetrator.
42	Women's Aid	Question 6	When safe and appropriate to do so it is vital that the utmost effort is made to ensure a conversation on a one-to-one basis is conducted. For some women, for example disabled women, their perpetrator of domestic abuse may also be their carer and it is important to recognise this dynamic and understand why it is important to talk to the person on a one-to-one basis. However, the Quality Standard must consider that some victims of domestic abuse might only want a one-to-one meeting with someone of their own gender, or they may have concerns about discussing the abuse with someone from their own community. A chaperone or meeting with someone of the same sex, or an alternative person must always be offered to the identified victim.
25	Cheshire West and Chester Council	Question 6(a)	A one to one discussion can take place with a service user who is potentially vulnerable by have a (staff chaperone) the word private should be seen as meaning a safe discussion ie where there will be no increase of risk to the service user by staff discussing DA in front of an alleged perpetrator/or family member or friend that could tell the alleged perpetrator.
25	Cheshire West and Chester Council	Question 6(b)	Discussion can only take place if the opportunity presents as safe for the victim.
39	AVA (Against Violence and Abuse)	Question 7	Private - consideration should be given to safety and to well-being. However, it may be appropriate to have two practitioners in the room to ask. It will depend on the setting - there is no reason why everyone in a maternity setting

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			can't be seen alone if thought is given to how this would be done. Consideration should be given to how and when someone will be asked and training would be able to support staff in identifying when and how to ask, we have expanded on the issue of training in responses to earlier questions. Providing information in toilets has proven to be a useful tool to help faciliate disclosure. Some schemes ask women to provide a urine sample and in the toilets provide information and small stickers to put on the sample tube if they want to talk to someone about abuse. The practitioner can then identify a safe way to talk to them alone. Other schemes ask the father to attend 'dad to be' sessions at the same time as the woman's appointment in order to facilitate a private session.
39	AVA (Against Violence and Abuse)	Question 7	When planning private, consideration should also be given to not raising the suspicions of the perpetrator if they are present. A simple way of asking an accompanying person to leave a room and giving a clear and simple response to what has been discussed when they re-enter the space will reduce the fear of the victim and the space for the perpetrator to be suspicious.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 7	**For draft quality statements 1 and 2: How should 'private' be defined within each setting?** The private discussion should take place in an environment where confidentially is assured, where the conversation cannot be overheard and in a safe space, with access to phone/language line for persons who require it.
31	British Medical Association	Question 7	Private one-to-one discussions should take place in cubicles with solid walls. Discussions taking place in patients' beds with curtains or with family and friends present cannot qualify as private. The patient should be alone with the health professional and a health service interpreter if needed.
3	City Health Care Partnership CIC	Question 7	**CHCP CIC Response:** As described above, private cubicle or consulting room; or in the service users own home a room in which there is only the service user and health care professional (with the exception of chaperone). Where the above is rejected, the staff should be opportunistic e.g. the toilet when samples asked for.
24	Durham County Council	Question 7	'Private' should be defined as keeping a physical distance from any other individuals with only healthcare professionals present. It is not reasonable to have a possible perpetrator or family member at the other side of a door/curtain and expect an individual to disclose abuse.
50	Hampshire Domestic Abuse Steering Group	Question 7	*For draft quality statements 1 and 2: How should 'private' be defined within each setting?* 'Private' should be defined as out of the sight and hearing of others.
14	Leeway Domestic Violence and Abuse Services	Question 7	Private should be defined as not being able to be overhead, for example asking them to step outside the curtain is not appropriate – if this is the only option consider cue cards that can be read within the curtained cubicle rather than spoken.
45	Mid Essex Hospital (NHS)	Question 7	Private must be a location where the conversation cannot be overheard by anyone other than the people involved.

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	Services Trust		Most health appointments and triage are in private locations so the health of the individual remains confidential. It simply requires that the third parties are required to leave the consultation area and sit in the waiting or public areas for a few minutes. In the A&E situation if the initial screening takes place at point of triage then this is a private location, the victim will be there for some time waiting for treatment and if there are significant risks identified there is the opportunity to ensure the attendance of a suitably trained practitioner who can carryout a more detailed assessment and undertake initial safety planning. If the initial screening does not disclose immediate high risk then person can be offered support through specialist services or referral to the police or other agencies as appropriate. All this can take place within the locations already in existence across the healthcare profession. If the recommendation for these QS to be extended across the health care field would mean that many consultations would be undertaken at people's own homes. Again if there is a directive for staff to follow that some part of the process must be one to one this may facilitate access to the person for the screening questions to be asked. If a third party refuses to leave the room then this would be a risk factor and any follow up visit should incorporate a strategy for a one to one conversation to take place. However at some point the screening must take place to protect the victim, give the potential perpetrator an opportunity to recognise and reform and to protect the practitioner by giving them an understanding of the situation the victim is in and how this can be managed most appropriately.
34	NIHR CLAHRC North Thames	Question 7	***Question 7: For draft quality statements 1 and 2: How should 'private' be defined within each setting?*** This question would best be answered by survivors of domestic violence themselves. Privacy is already enshrined in a number of NHS policy documents, including the NHS Constitution (2013), and as such any clinical setting should already have a policy on maintaining privacy for patients. For potential victims of domestic violence, privacy could be defined as a space where they may feel comfortable to disclose, i.e. where they cannot be overheard by perpetrator, by other members of the public or by staff.
43	North Essex Partnership (NHS) Foundation Trust	Question 7	Private must be a location where the conversation cannot be overheard by anyone other than the people involved. Most health appointments and triage are in private locations so the health of the individual remains confidential. It simply requires that the third parties are required to leave the consultation area and sit in the waiting or public areas for a few minutes. In the A&E situation if the initial screening takes place at point of triage then this is a private location, the victim will be

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			there for some time waiting for treatment and if there are significant risks identified there is the opportunity to ensure the attendance of a suitably trained practitioner who can carryout a more detailed assessment and undertake initial safety planning. If the initial screening does not disclose immediate high risk then person can be offered support through specialist services or referral to the police or other agencies as appropriate. All this can take place within the locations already in existence across the healthcare profession. If the recommendation for these QS to be extended across the health care field would mean that many consultations would be undertaken at people's own homes. Again if there is a directive for staff to follow that some part of the process must be one to one this may facilitate access to the person for the screening questions to be asked. If a third party refuses to leave the room then this would be a risk factor and any follow up visit should incorporate a strategy for a one to one conversation to take place. However at some point the screening must take place to protect the victim, give the potential perpetrator an opportunity to recognise and reform and to protect the practitioner by giving them an understanding of the situation the victim is in and how this can be managed most appropriately.
6	Northumberland Tyne and Wear NHS Foundation Trust	Question 7	*For draft quality statements 1 and 2: How should 'private' be defined within each* setting? Opportunity to be listened to and not overheard by visitors, family members etc
7	Public Health England	Question 7	Confidential services are paramount however see examples below: <u>Mat services</u>, we actively encourage fathers to be involved in pre and post-natal maternity care therefore, so we need to find creative ways to legitimately allow for women who are experiencing DV to be seen separately from their partners. Birmingham has a initiative where women use a sticker on a sample bottle to alert staff. <u>A&E</u> – Women have reported feeling as though the perpetrator is still with her despite being on her own…he is never far away. Services may only get one opportunity to engage with that woman so it is important to understand how best to communicate in a way that does not expose that woman to more violence. How we effectively recognise those fears?. By exposing that woman are seeking help, risk level increases significantly (83% of deaths in Birmingham happen when a woman is seeking help).
33	Rotherham Doncaster & South Humber NHS Trust	Question 7	No – definition should be provided.
4	Royal College of Paediatrics and Child Health	Question 7	'Private' discussion should be in a separate room; just pulling curtains around a cubicle in A&E should not be enough.

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35	South West Yorkshire Partnership[NHS Foundation Trust	Question 7	Private has to include the above statement about the perpetrator being present Private has to give consideration to being away from A&E due to this setting of A&E being one of heightened bodily exposure and a mixed sex environment.
11	The Royal College of Midwives	Question 7	A private room where they can talk without interruption or in view of passers by.
22	University of Central Lancashire (UCLAN)	Question 7	A space where the patient cannot be overheard – ideally a separate room/office. If the person would like a friend/relative they trust to be present, this should be accommodated.
42	Women's Aid	Question 7	In the context of these quality standards 'private' should always mean somewhere where the person feels comfortable and confident that they will not be overheard. Ideally this will always be a room with a door, and not, for example, a curtain around a bed in a hospital ward. Private should always be defined as without the person's partner/husband/wife or any family members.
25	Cheshire West and Chester Council	Question 7(a)	Private discussion means safe to do so as above in Q6. Seeing a service user alone so as not to increase risk.
25	Cheshire West and Chester Council	Question 7(b)	Within health care the definition of private should be interpreted as belonging to a person and information held is confidential and only shared with the patient's permission or on a need to know basis for protection / public interests.
39	AVA (Against Violence and Abuse)	Question 8	There are existing risk assessment tools that could be used, including the DASH. Additional questions may need to be asked to young people as no current risk assessment tool adequately covers their needs. Any assessment should be elad by the person experiencing violence and abuse Thought should be given to safeguarding implications of disclosure and how this is managed. Assessment of safety will also depend on local area models - it may be that a joint referral pathway could be made across local areas that work between health, local authority and criminal responses.
29	British Association of Sexual Health and HIV (BASHH) Sexual Violence Group	Question 8	**For draft quality statement 3: What should an 'assessment of immediate safety' involve?** Details are needed about who the perpetrator is, what they are afraid of, when the last episode happened and what happened during the worst episode. To understand if the abuse is escalating and who else may be involved in perpetrating the abuse and who else may be affected by the abuse. To understand if the patient has a safety plan and to ensure that the patient has given up-to-date contact details and that it is safe/ when it is safe to contact them. If there is current (within the last 3 months) or risk of on-going abuse (i.e. the perpetrator is about to be released from prison) a CAADA DASH risk assessment is a useful tool to assess the level of risk

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			Assessment of immediate safety includes, • Asking if they have concerns about their own safety and /or that of others e.g. children or threats to family members and making a decision regarding police involvement • Assessing if children are at risk and discussing the need for a safeguarding referrals (adult or child) • Assessing immediate needs for safety planning such as accommodation and money/resources • Ensuring a safe mode of contact to liaise with patient for follow up • Assessing for history of harmful coping strategies including but not limited to drug and alcohol use and self harm and involving other services if indicated • Assessing suicide risk • Asking what they think would make them safer- Would 'storm makers'/ assurance of rapid police response help? Asking them to plan ahead- what would they do if they felt unsafe? Are numbers in phone ready?
31	British Medical Association	Question 8	An 'assessment of immediate safety' should consider the following: - Is the perpetrator free to continue to commit the acts of violence? Has he/she been arrested, if so how long are they likely to be detained? - Is there somewhere the victim can go that is unknown to the perpetrator? - What is the risk of the victim getting in danger again? - Does the victim rely on the perpetrator for something e.g. drugs/money, so that they feel they need to actively seek out the perpetrator? Are there children involved who are also at risk?
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Question 8	Assessment of risk should involve commonly used CAADA DASH but additions for immediate safety added. Assessment of immediate safety may be as simple as asking is it safe to go home? Specific action – engage multi-agency partners in risk assessment and safeguarding
3	City Health Care Partnership CIC	Question 8	**CHCP CIC Response:** we have identified the following requirements: • Use of a simple, relatively quick and straight forward, possibly nationally approved and developed risk assessment tool. For example, something along the lines of the Brook Spotting the Signs proforma which is used for the identification of risks associated with child sexual exploitation or the Edinburgh PND. • The proforma, should be adaptable to local use • It should include recommended risk scores and outcomes. • We would recommend that there is potentially a single point of contact for those identified as being at high and/or immediate risk

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			• The associated pathways should be multi-professional and involve the 3rd sector • Support should be available 7 days per week including out of normal working hours periods.
24	Durham County Council	Question 8	This should be carried out in line with locally adopted risk assessment procedures. Currently CAADA-DASH risk identification checklist is adopted within County Durham. This is carried out with a referral to MARAC if high risk. County Durham has an adopted Multi-Agency Domestic Abuse Referral Pathway which clearly identifies pathways for differing levels of risk.
50	Hampshire Domestic Abuse Steering Group	Question 8	*For draft quality statement 3: What should an 'assessment of immediate safety' involve?* DASH risk assessment
47	Institute of Health Visiting	Question 8	The victim having a plan for their own safety and that of their children and providing support to implement this, where necessary. The risk of murder/serious harm at the time of 'leaving' is well documented in the research and in studies linked to domestic homicide reviews (DHR). Health professionals can offer some practical and emotional support, but should refer to specialist DVA services. MARAC is an important source of safety planning and there could be plans already in place in high-risk situations.
14	Leeway Domestic Violence and Abuse Services	Question 8	An assessment of immediate safety should ideally involve the DASH risk Assessment (Domestic Abuse, Stalking and Harassment) however if that is not appropriate it should involve asking the patient if they feel safe going home as they will be the only one that knows if the abuse is likely to escalate.
45	Mid Essex Hospital (NHS) Services Trust	Question 8	This should be undertaken as a basic risk identification process, using the levels of fear of the victim as one of the key guiding factors. If this short question set identifies an immediate risk of serious harm or death then this would require immediate safety planning to safeguarding the person both at the healthcare location and subsequently. An assessment of immediate safety should be short and to the point so that immediate risk can be identified. The term "immediate safety" may be misleading as the victim (and perpetrator) will be normally be safe during their period at the health care location. Therefore the issue is actually the level of risk to the victim when he or she leaves that location and how immediate and severe that is. The role of the initial screening is to give an indication of risk and for this to be referred to a trained professional for a more details assessment, initial risk minimisation planning, referral to appropriate agencies for safeguarding on leaving the location and emotional and practical support whilst a patient or service user at the health care location. Where the service user is in the community and the screening has taken place in the home, an assessment of risk will allow the practitioner to give supportive advice, make relevant and appropriate referrals and gie the victim an opportunity to link with specialists under the support of the community healthcare professional. Where the risk is

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			immediate and severe the normal processes for police and other agency contact would be undertaken as is currently the practice across agencies.
34	NIHR CLAHRC North Thames	Question 8	***Question 8: For draft quality statement 3: What should an 'assessment of immediate safety' involve?*** The approach taken in the Identification and Referral to Improve Safety (IRIS) model for primary care (Feder et al., 2011) involves GPs asking: - Is it safe to for the victim to return home? - Are there children at home and are they at risk of abuse?
43	North Essex Partnership (NHS) Foundation Trust	Question 8	This should be undertaken as a basic risk identification process, using the levels of fear of the victim as one of the key guiding factors. If this short question set identifies an immediate risk of serious harm or death then this would require immediate safety planning to safeguarding the person both at the healthcare location and subsequently. An assessment of immediate safety should be short and to the point so that immediate risk can be identified. The term "immediate safety" may be misleading as the victim (and perpetrator) will be normally be safe during their period at the health care location. Therefore the issue is actually the level of risk to the victim when he or she leaves that location and how immediate and severe that is. The role of the initial screening is to give an indication of risk and for this to be referred to a trained professional for a more details assessment, initial risk minimisation planning, referral to appropriate agencies for safeguarding on leaving the location and emotional and practical support whilst a patient or service user at the health care location. Where the service user is in the community and the screening has taken place in the home, an assessment of risk will allow the practitioner to give supportive advice, make relevant and appropriate referrals and gie the victim an opportunity to link with specialists under the support of the community healthcare professional. Where the risk is immediate and severe the normal processes for police and other agency contact would be undertaken as is currently the practice across agencies.
6	Northumberland Tyne and Wear NHS Foundation Trust	Question 8	*For draft quality statement 3: What should an 'assessment of immediate safety' involve?* As written in statement 3 above
7	Public Health England	Question 8	• Creating Safety plans – women are best determinants of their own safety. Services need to support them to make informed choices; Services need to be listening to the women in order to determine how they can help. • Specialist services – Specialist services are decreasing, austerity and funding cuts require a different approach. Partners will need to come together to apply the principles of strategic commissioning which is

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			based upon an assessment of need, an understanding of what already exists, evidence based practice, pooled budgets and shared priories which put women at the centre.
33	Rotherham Doncaster & South Humber NHS Trust	Question 8	Review of individual circumstances – risk history, vulnerabilities including historical and potential.
20	Sanctuary Supported Living- Housing Association	Question 8	. This should involve at least a DASH risk assessment completed by trained staff . Ideally it should involve being seen by an IDVA with actions to keep the client safe being taken e.g. referral to Refuge . The option to report to the police
49	Sheffield City Council	Question 8	***Response to Question for consultation*** What should an 'assessment of immediate safety' involve? There is national agreement on key risk factors currently e.g. those incorporated in the DASH risk assessment. These can be summarised into 'health specific' but care needs to be taken not to remove consideration of risk factors that will help practitioners identify coercive control e.g. questions about stalking and harassment, isolation and jealous and controlling behaviour.
35	South West Yorkshire Partnership[NHS Foundation Trust	Question 8	Immediate safety protocol would need to be embedded into policies and training This would include (where possible) a multi-agency response.
11	The Royal College of Midwives	Question 8	If DA is disclosed a DASH risk assessment could be completed or at the least the victim should be asked if they are safe to return home. Skilled professional judgement will be needed as often a victim will minimise the abuse.
22	University of Central Lancashire (UCLAN)	Question 8	An assessment of immediate safety should include the level of immediate risk of harm to the victim. This should not just rely on a tick box risk factor approach, but should also include a genuine dialogue with the service user as to what they need immediately and in the next few days to keep them safe.
42	Women's Aid	Question 8	We welcome the focus on an assessment of safety, rather than risk, of the person accessing health services. Through the development of our Change that Lasts model we have identified that in order to achieve safety for survivors and their children it is necessary to assess their needs. This needs assessment would be based on the strengths and needs of the individual and build on their resources. An effective needs assessment would address the safety and risk of a victim along with any children. Women's Aid will be developing a needs assessment that we will then pilot and would be happy to share learnings with NICE.
25	Cheshire West and Chester Council	Question 8(a)	Completing an evidenced based DA Risk Assessment using an evidenced based tool. Or if this is not possible using professional judgement to assess risk. Ensuring that if there is a concern of immediate risk of harm that staff take steps to help to ensure the service user's safety.
25	Cheshire West and	Question	Agree with description in draft guidance.

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	Chester Council	8(b)	
		Question 9	In order to ensure genuine and effective multi agency working this could be achieved by developing a quality standard on safe and appropriate information sharing so healthcare professionals feel confident in responding to disclosures of domestic abuse and how they can signpost and support victims,
39	AVA (Against Violence and Abuse)	Question 9	A focus on referral pathways would be useful - to create a joined up community response. To reiterate the point made in question 1 - it would be good to include a specific standard related to strategic partnership working and local strategic responses. This may also help with the questions around adequate data collection.
3	City Health Care Partnership CIC	Question 9	**CHCP CIC Response:** we have identified the following potential actions: • Ensure the partnership is truly multi-agency and functions like a locally managed network: involve police, social services, safeguarding teams, a wide variety of healthcare professionals, drug and alcohol services, perpetrator and victim support services, probation services, representatives from primary and secondary care, sexual health services, maternity, unplanned care etc. • Ensure user and/or advocacy involvement • Ensure the work of the partnership is widely promoted and embed marketing what is provided/ access to the 2 'customers'; providers of care and the public • City wide initiatives, for example to advertise services for victims and perpetrators • Clear 24/7 referral routes, support and advice – consider a single point of contact. • Use of technology for example to source best practice guidelines, referral information, booking and access to services • Focus on prevention of violence and abuse, for example working with at risk groups, in schools, colleges etc. link to SRE type training • Holistic care for victims, for example optimising life choices and chances of victims. • Link adherence to standards and NICE guidance relating to domestic violence to CQC visits. • Development of standardised and approved assessment tools • National standards for training and development • Provision of support services for families at risk or in crisis, for example debt management etc. whereby support is provided prior to relationship breakdown or abuse commencing. • Customer feedback Participate in national campaigns
24	Durham County Council	Question 9	Within County Durham the Safe Durham Partnership is the multi-agency partnership which leads on domestic abuse.

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			The Safe Durham Partnership is made up of representatives from Durham County Council, Durham Constabulary, Durham & Darlington Fire & Rescue, DDES Clinical Commissioning Group, County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valley NHS Foundation Trust, HMP Durham, Office of the Police & Crime Commissioner. Specific actions for the partnership to improve quality in this service would include: • Joint commissioning of specialist domestic abuse services. • Identification of joint priority areas for development based on evidence. • Development and awareness raising of referral pathways. • Piloting of innovative approaches to tackling domestic abuse. • Sharing of best practice. • Mapping of services that exist within a locality. • Governance of local management processes such as MARAC. • Lead on the conduct of Domestic Homicide Reviews and governance of any subsequent action plans.
50	Hampshire Domestic Abuse Steering Group	Question 9	*What specific actions should be undertaken by this multi-agency partnership or outlines in integrated strategies to improve quality in this service?* Joint commissioning of support services Multi-agency training (and associated funding) Involvement with and commitment to local DA strategies and boards
47	Institute of Health Visiting	Question 9	We agree with the need to develop an integrated commissioning strategy for DVA. This might usefully be included as part of the transfer to local government of health visitor services. Local leadership is key. Health visitors report that DVA can fall between 'safeguarding children' and 'safeguarding adults' provision - having a named lead for DVA within provider organisations is crucially important; as are good policies and protocols and excellence in training and awareness raising.
14	Leeway Domestic Violence and Abuse Services	Question 9	Multi agency partnership working is paramount to any strategy working effectively therefore knowlede of local agencies and good communication methods must be established.
45	Mid Essex Hospital (NHS) Services Trust	Question 9	Consistent reporting and recording requirements across the healthcare environment is essential to feed into a multi-agency assessment process which can effectively consider the risk to individuals experiencing DVA, their children

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			and adults at risk from the situation. Multiagency hubs are one of the key factors in providing information and allocating resources to support individuals and their families. However these are currently very child focussed and few have sufficient resources for cases involving adults at risk or where there are no children or adults at risk within the situation. Whilst there are obviously data protection factors which must be respected in situations involving capacitous adults or adults at risk with capacity, this does not prevent the agency identifying the abuse from offering support, guidance and seeking advice from specialists to ensure that the best service is given to the victim and potential perpetrator. The key factor for referrals to multi-agency and specialist services is to ensure that they are in place for men and women and there are sufficient resources to ensure that where a referral is made, it is acted on in a timely and effective fashion. An additional standard relating to the provision of specialist services, the integrated approach and setting up of multiagency processes would be of considerable benefit. As previously outlined, issues such as the provision of support services are not solely in the gift of the health service. They sit under the funding streams provided to Police and Crime Commissioners with support (financial and practical) from partners to ensure there are sufficient resources to undertake this role.
34	NIHR CLAHRC North Thames	Question 9	*Question 9: The Quality Standards Advisory Committee recognised that multiagency partnership working and an integrated strategy are important approaches for managing domestic violence and abuse.* *What specific actions should be undertaken by this multi-agency partnership or outlined in integrated strategies to improve quality in this service?* As reiterated throughout this consultation response, multiagency partnership working and an integrated strategy are vital for improving the response of the health sector to DVA. Specific actions that should be taken by multi-agency partnerships are: - Develop a locally agreed strategy on DVA - Develop data sharing arrangements - Jointly commission support and prevention services - Involve victims of DVA in the development and delivery of the DVA strategy **References**

ID	Stakeholder	Statement number	Comments[3]
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			Williamson, E., Jones, S. K., Ferrari, G., Debbonaire, T., Feder, G., & Hester, M. (n.d.). Health professionals responding to men for safety (HERMES): feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse. *Primary Health Care Research & Development*, 1–8. Retrieved from http://journals.cambridge.org/abstract_S1463423614000358 Humphreys, C, Thiara, R and Regan, L. (2005). Domestic violence and substance use: Overlapping issues in separate services? Online http://www.avaproject.org.uk/media/25289/domestic%20violence%20and%20substance%20use%20overlapping%20issues%20in%20separate%20services.pdf Accessed 02/07/15
43	North Essex Partnership (NHS) Foundation Trust	Question 9	Consistent reporting and recording requirements across the healthcare environment is essential to feed into a multi-agency assessment process which can effectively consider the risk to individuals experiencing DVA, their children and adults at risk from the situation. Multiagency hubs are one of the key factors in providing information and allocating resources to support individuals and their families. However these are currently very child focussed and few have sufficient resources for cases involving adults at risk or where there are no children or adults at risk within the situation. Whilst there are obviously data protection factors which must be respected in situations involving capacitous adults or adults at risk with capacity, this does not prevent the agency identifying the abuse from offering support, guidance and seeking advice from specialists to ensure that the best service is given to the victim and potential perpetrator. The key factor for referrals to multi-agency and specialist services is to ensure that they are in place for men and women and there are sufficient resources to ensure that where a referral is made, it is acted on in a timely and effective fashion. An additional standard relating to the provision of specialist services, the integrated approach and setting up of multiagency processes would be of considerable benefit. As previously outlined, issues such as the provision of support services are not solely in the gift of the health service. They sit under the funding streams provided to Police and Crime Commissioners with support (financial and practical) from partners to ensure there are sufficient resources to undertake this role.
6	Northumberland Tyne and	Question 9	*The Quality Standards Advisory Committee recognised that multi-agency partnership working and an integrated*

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	Wear NHS Foundation Trust		*strategy are important approaches for managing domestic violence and abuse.* *What specific actions should be undertaken by this multi-agency partnership or outlines in integrated strategies to improve quality in this service?* Multi agency pathways of care for those who are victims or perpetrators of dv and abuse. Multi agency training and resources available to manage the safety planning required for those vulnerable people who are hard to reach or difficult to engage with services.
7	Public Health England	Question 9	• Value specialist sector – The Third Sector have significant experience of protecting women and children, closer relationships with the voluntary and community sector could engender skills sharing • Address the imbalance of time spent on multi-agency assessment where there are no interventions and re-invest agency time in providing **early help** • Need to change the culture of all organisations by having and understanding or cohersive controls and defining DV from an incident based approach • Approach should be based on empowerment Each agency must hold responsibility and not pass on to Social care.
30	R.I.S.E.	Question 9	In our local MARAC info from A&E admissions is being shared to enable the Conference to assess the risks to victims better. Information shared by the MARAC with A&E departments and other health practitioners could be also helpful – for example: would having an alert on A&E systems informing that the patient attending has been identifies as a high risk victim of DV be supportive both for the staff and the victim?
33	Rotherham Doncaster & South Humber NHS Trust	Question 9	Clear benchmarks, joint publications, recognised and promoted evidence base and promotion of centre of excellence.
35	South West Yorkshire Partnership NHS Foundation Trust	Question 9	The establishment of Domestic violence job roles would have to be created to ensure a multi-agency response and to ensure appropriate response to an increasingly demanding area.
32	Standing Together against Domestic Violence	Question 9	Domestic abuse is a complex social problem which cannot be effectively tackled by a single agency and requires a coordinated community response. Standing Together has produced specific guidelines on how to create effective local domestic violence partnerships ('In Search of Excellence: A Guide to Effective Partnerships', 2011, Standing Together against Domestic Violence). The key components of a successful partnership can be summarised as follows: • **Shared Objectives:** All partners commit to a shared vision, a set of shared objectives and understand the need to work together on equal terms. • **Structure and Governance:** The partnership is accountable, has strategic direction and the ability to deliver

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			operational outputs. • **Strategy, Leadership and Action Plan:** The intentions of the partnership and the action plan include prevention and early intervention alongside high risk responses. • **Representation:** All relevant agencies are appropriately represented. The voluntary sector is valued for its specialist expertise. • **Resources:** The partnership is aware of the cost of domestic violence to its members each year. The strategy matches the availability of funding. • **Coordination:** Partners are committed to the principles of a coordinated system of response. • **Training:** All partner agencies have a shared understanding of the dynamics of domestic violence. Front-line staff and their managers have the skills and knowledge to identify and respond to domestic violence. The approach to training is linked to the partnership's strategy, policies, and procedures. • **Data:** All partners contribute data that is collated for the whole partnership and there is a system of accountability to which all partners submit. • **Policies, Protocols and Processes:** Shared multi-agency policies and protocols are in place to address all key areas of action with regular review dates. • **Specialist Services:** Sustainable provision of specialist services for survivors of domestic abuse (including IDVAs and ISVAs). • **Diversity:** Equality and diversity considerations are embedded in all decision making and service planning. Equality analysis/impact assessments are carried in the development of policies and services. • **Survivors' voices:** There is a system in place to capture the experiences of survivors. Services and procedures are shaped and reviewed in accordance with feedback from service users.
22	University of Central Lancashire (UCLAN)	Question 9	1) Assessment of risk should be revisited and not be seen solely as individual incident based. 2) The notion that adult service users (with no children or adult children) need to have additional vulnerabilities (i.e. additional to domestic abuse) needs to be dispelled. 3) Multi-agency partnership should ensure that diversity issues are considered and evaluated 4) Commissioners should ensure that there are properly resourced specialist domestic abuse services
25	Cheshire West and Chester Council	Question 9(a)	There must be agreed multi agency practice guidance endorsed by the LSCB and LSAB that all agencies work together with to ensure consistency and compliance.
25	Cheshire West and Chester Council	Question 9(b)	A multi-agency risk assessment conference would provide a good model for sharing information and outlining an action plan.
5	PARITY Equal Rights for Men and Women	Source guidance –	'intrusive 'other person' in consultations including partner or **husband**, parent, grandparent or an adult child (for elder abuse). Why no '**wife**'? Word '**spouse**' should be used for gender neutrality.

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		Definition of terms used - page 10	
25	Cheshire West and Chester Council	Statement 1	**Comment 1-** There could be disadvantages in identifying 'at risk' groups, as a stereotype of abused people could be developed. This would have to be weighed against the risk of abuse being missed in certain communities as they are assumed to be at lower risk of abuse. The important message is that domestic abuse happens in all communities, to people of all genders, ages, ethnicities, employment status, abilities/disabilities, whether they are Lesbian, Gay Bisexual or Trans.
25	Cheshire West and Chester Council	Statement 1	**Comment 2** - The term private should mean NOT in a place where anyone known to the patient can overhear or even know about the interview and thus reduce the likelihood of a disclosure. At this stage it will not be known whether the patient's friend/partner/carer may be the abuser. The term therefore does not just relate to the situation or physical layout of a room.
50	Hampshire Domestic Abuse Steering Group	Statement 1	*People presenting to A&E departments with indicators of possible domestic violence or abuse have a private one-to-one discussion.* • It should be stated that in having a discussion with someone, a direct questions needs to be asked about domestic violence/abuse. Research has shown that many people won't disclose abuse off their own backs, but will (and are relieved to) if asked a very direct question. • Healthcare professionals: need to add some information about the requirement for professionals to make appropriate onward referrals (even to external support agencies) and to SHARE INFORMATION as appropriate with other agencies, particularly DA support agencies and MARACs – rather than feeling bound by patient confidentiality (as is so often the case when non-health agencies try to engage with health services).
36	London Borough of Enfield	Statement 1	The draft quality standards do not accurately reflect the key areas for quality improvement giving no mention that training is included and no mention of integrated local strategies. Given time restraints and lack of coordination or framework in A&E departments for those presenting with indicators of domestic violence or abuse this quality standard falls short of being able to be implemented effectively.
17	NCSPVA, University of Worcester	Statement 1	Ensure people who misuse alcohol or drugs or who have mental health problems and are affected by domestic violence and abuse are also referred to the relevant health, social care and domestic violence and abuse services. I would recommend that those presenting with complex and multiple needs are cared for holistically rather than passed from agency to agency as can occur when there are several competing needs involved.
7	Public Health England	Statement 1	The focus upon A&E in this section is good but there is merit in expanded the guidelines to include GP services and Mental Health services where women can often present as a result of physical and/or psychological abuse. There

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			are lessons to be learned by reviewing outcomes from domestic homicide reviews which show that a first contact with a woman who experiences DV is unlikely to glean any information. It is only when a professional is able to establish a trusting relationship with that woman, will she feel able to share/disclose her experiences. Maternity services are generally good in terms of their approach to DV and the services offered are generally reported as being positive therefore, we are not sure that the maternity services needs to be revisited within the context of this guideline?
30	R.I.S.E.	Statement 1	Specific at risk groups: Young people especially LGBT; women who recently came to this country and do not speak the language and especially those who are pregnant/recently had a baby, women with disability. An exception to “one-to-one” could be another professional (a person who has a duty to keep info shared confidential).
41	Research in Practice	Statement 1	Professionals should take into account the capacity of individuals, including children and young people who may have experienced domestic violence, to consent and to participate in a discussion, and support provided where needed. This should not involve using family members as interpreters or to facilitate communication.
13	SafeLives	Statement 1	The 'indicator' set needs to be explicitly and directly drawn from previously issued national best practice. 1-1 discussions to help establish whether abuse is taking place must use a method of questioning which is proven to facilitate safe disclosure ii) it is essential for A&E staff to have training to be able to identify the indicators of possible DVA as without this, they will not have the confidence to ask for disclosure ii) Further, it is equally important that there are genuine referral pathways to specialist services for support iv) Finally, they must understand the links between DVA and child safeguarding so that they are able to respond to both the adult and child victims v) the impact of this must be tracked in terms of numbers of people identified and % referred for specialist help, % engaging etc vi) commissioning guidance must reflect this and allow for capacity to carry this out.
12	Somerset Integrated Domestic Abuse Service (SIDAS)	Statement 1	***Quality statement*** People presenting to A&E departments with indicators of possible domestic violence or abuse have a private one-to-one discussion. **Are there specific ‘at risk’ groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?** SIDAS currently have an A & E IDVA in Yeovil and Taunton Hospitals. These two workers are on a year’s contract to work within A & E and Maternity in both hospitals (also undertake some research in Urology, Orthodontics and GUM Clinics). They are there to research current practice, identify gaps in practice and fully train staff in the departments (nurses and consultants) to ‘ask the question’ and identify those at risk. They also offer training on looking at the indicators of abuse, but are both aiming for routine enquiry with all patients coming into the hospital due to some

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			individuals not having obvious indicators of abuse. **Given that this population may involve vulnerable patients, in practice would a discussion always take place on a one-to-one basis?** At present it's currently not always done on a one-to-one basis, there is usually more than one member of staff around and as staff are not all 'asking the question' it's very dependent on those who are confident on asking. The Hospital IDVA's are doing a section in their staff training on how to work with individuals who disclose. **How should 'private' be defined within this setting?** In both A & E's there is a degree of privacy as the patients are all in individual curtained booths. If a disclosure does happen then they should be moved into one of two rooms allocated for privacy. From research being done by the IDVA's the movement of patient's into a private room is not always happening, but again this is part of their training package with all staff. 'Private' should be defined as a space away from others who can hear the conversation and somewhere safely away from the perpetrator. The possibility of the individual being asked during the triage process is also being looked into, as it the 'dot on the pot' scheme whereby the victim identifies themselves during a private routine urine sample by sticking a spot on their sample pot. They can then be moved somewhere 'private' for disclosure to take place.
32	Standing Together against Domestic Violence	Statement 1	Quality statement 1 should recommend that "People presenting to A&E departments with indicators of possible domestic violence or abuse have access to a private one-to-one enquiry (as opposed to discussion) around domestic violence and abuse. Our experience has shown that unless professionals are specific about the need to 'ask the question' and patients are not asked directly, disclosures can often be missed.
16	Stonewall	Statement 1	Stonewall's research into lesbian, gay and bisexual (LGB) people's experiences of healthcare has found that despite being at a high risk of experiencing domestic violence, a significant proportion of LGB service-users do not feel comfortable being open about their sexual orientation with healthcare professionals.[1,2] This makes it difficult for individuals to report domestic violence and to access support services. Many LGB service-users expect to face discrimination when accessing routine healthcare services. In the case of domestic violence this can be compounded by a lack of awareness amongst professionals that domestic violence can occur in same-sex relationships.[3] Little specific research exists into trans people's experiences of domestic violence, however a study by the Scottish Transgender Alliance found that trans people are at a high risk of experiencing domestic violence and face barriers to accessing support services.[4]

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			Service-providers can tackle this by training frontline staff in the use of sensitive and gender-neutral language when asking about domestic violence in order to encourage disclosure. This should from part of the Equality and Diversity considerations for this Quality Statement. 1. 49% of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16. 25% of lesbians and bisexual women have experienced at least one incident of domestic abuse in a relationship. - *Domestic abuse – Stonewall Health Briefing (2011)* 2. 49% of lesbians and bisexual women, and 34% of gay and bisexual men are not out to their GP or healthcare professional. This corresponds with service-users' experience of healthcare with 52% of lesbian and bisexual women and 34% of gay and bisexual men reporting negative experiences related to their sexual orientation. *Experiences of Healthcare – Stonewall Health Briefing (2011)* 3. 7% of LGB people expect to face discrimination when accessing GP services. This rises to 12% of LGB people aged 18-25. *Gay In Britain (2013)* *4.* 80% of respondents stated that they had experienced emotionally, sexually or physically abusive behaviour by a partner or ex-partner with 45% reporting physical abuse. 24% of respondents did not report this to anyone. *Transgender People's Experiences of Domestic Abuse (2010)*
22	The ManKind Initiative	Statement 1	Male victims of domestic abuse must be included in the underrepresented groups for a number of reasons. Firstly, they are under recognised throughout the health system because the narrative for several decades on domestic abuse has been that it is an issue that only affects women. From our experience and the experience of those men who call our helplines, they still find it unrecognised when they come into contact with the health and social care services. For example, can NICE have confidence that every single piece of training healthcare professionals receive fully recognise male victims and that the professionals fully recognise the existence of male victims in the same way they rightly do for female victims. Adding men in this section would ensure that pressure was placed on health bodies and professionals to comply with the NICE Guidelines (PH50) on issues such as local data collection especially with the need to be able to refer male victims onto other services. This is not only a positive intervention and support in itself, it will also apply pressure on statutory authorities to ensure those services actually exist. The latter would ensure men would have access to the same type of journeys and escape routes female victims have but also this would ensure better compliance of the NICE Guidelines (PH50) and also the Equality Act (2010) – especially the Public Sector Equality Duty. Secondly, men are far more reluctant than female victims to come forward. There are a number of reasons for this from the fear of not being believed, shame/pride and a sense of helplessness because they never see/hear campaigns about male victims so are not aware there is support for them. This has been recognised in official

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			guidance from the Department for Public Prosecutions on handling domestic abuse cases – section 70 male victims (published 29 December 2014). In addition, British Crime Survey figures produced by the Office for National Statistics shows there are gender differences in whether victims of partner abuse disclose to official bodies: Telling someone in an official position: 22% men – 38% women Telling a health professional: 10% men – 15% women (Source - ONS BCS Focus on Violent Crime and Sexual Offences 2012/13 http://tinyurl.com/nb4xga; Table 4.22 on Appendix Table: http://tinyurl.com/qgxb7xg Due to this level of under-reporting, it is likely that not to mention/include male victims in the equality and diversity section may breach the Public Sector Equality Duty (Equality Act 2010) as they are clearly a disadvantaged group
11	The Royal College of Midwives	Statement 1	People do not always present with indicators such as injuries, for this reason everyone should be asked about DA.
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	'people presenting in an A & E setting'. People may also disclose in a healthcare setting not just A & E
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	Will there be a requirement to provide private 1 to 1 facilities and capacity for staff to facilitate and what is defined as 'private'
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	What evidence will be required to show local arrangements
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	Will evidence of numbers of staff trained be sufficient and is there a descriptor to identify types of training i.e e-learning or face to face
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	Systems need to be developed for staff to record the numbers locally and then coordinated corporately
2	5 Boroughs Partnership NHS Foundation Trust	Statement 1	Healthcare professionals. Making kind and considerate enquiries should also include a consideration for the professional to feel safe, for example if the perpetrator is also is or likely to be in attendance
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Statement 1 + 2	Focussing on risk with indicators may miss cases not fitting criteria
8	Broken Rainbow UK	Statement 1 and 2	It is also feasible that the perpetrator may follow them to the hospital and present as someone else, such as a friend or sibling. Again extra consideration needs to be given in allowing access to the patient and whether doing this puts the patient at risk.
1	General Medical Council	Statement 1	It is not clear to us why GPs' surgeries are not included as one of the settings in which people presenting with

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		and 2 Question 4	indicators of possible domestic violence or abuse should have a private one-to-one discussion. As key providers of primary healthcare, GPs are in a good position to identify indicators of violence and abuse. Almost all of the indicators listed in the quality standard (pages 10 and 14) are symptoms or conditions that patients are likely to see their GP about, and many would not directly lead a patient to go to an accident and emergency department or maternity service, although they could of course be identified by these services in the course of other treatment or care.
37	Leicestershire Partnership NHS Trust	Statement 1 and 2	• Disclosures made in A and E are too late to prevent physical and emotional harm that has already happened. • Maternity services can pick up only one sector of vulnerable people and victims i.e. what about older women, same sex relationships, older people and men! • These 2 statements could create false assurance that we are 'asking the question'. I agree with statements 1 and 2 but think they need to add something that would encompass other groups. The obvious one would be for GPs and practice staff. That would pick up the majority of the population.
19	London and South Perinatal Consultant Psychiatrists	Statement 1 and 2 Questions 4 and 5	In addition to the populations specified, could the committee include mental health service users who also need to be asked about DV on a one-to-one basis? We know that this is not currently happening in routine care but people in contact with mental health services including IAPT services are particularly likely to have experienced domestic violence (Khalifeh et Al Psychological Medicine 2014 found 27% of women mental health service users for example reported recent (within last year) domestic violence and more than 60% had experienced DV since the age of 16).
45	Mid Essex Hospital (NHS) Services Trust	Statement 1 and 2 Question 4	Please see answer to Question 1 Although well-intentioned it is clear from the DHR and other reviews carried out that A&E are not the primary point of contact for victims and perpetrators of DVA, especially male victims of female abuse. Most people experiencing or perpetrating DVA are likely to engage with their GP or community services far earlier than with an acute service when the level of violence has reached a point at which hospital attendance is required. Research in Essex has indicated that even high risk victims are more likely to be engaging with primary and community services than A&E and many of the victims would not have come into contact with maternity services as they either had no children, their children were older or they were male. These Quality Standards must apply across all primary and commissioned services to ensure that psychological and emotional harms are given equal status with physical and sexual abuse. A community mental health professional is more likely to identify coercive control and psychological abuse than an A&E nurse especially where the person experiencing the abuse has not recognised it as such.

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			All services commissioned by CCG and GP primary care must be included in these standards if we are to identify abuse against any one where DVA is affecting children and adults at risk living within the household. Within the hospital scenario it is also clear that many people will attend the hospital as an outpatient, for surgery, for specialist admissions without attending A&E, therefore the aim must be for patient records to link across the health sector so that; for example, when a person attends an outpatient appointment there is a marker on their file indicating whether they have previously been screened and the outcome so the professional is able to better assess both the patient and the services required. Therefore it is not just A&E within the acute sector who should undertake DVA screening (whether routine or targeted) to ensure that abuse is always considered by the attending practitioner as a cause or underlying issue for that individual.
43	North Essex Partnership (NHS) Foundation Trust	Statement 1 and 2 Question 4	Please see answer to Question 1 Although well-intentioned it is clear from the DHR and other reviews carried out that A&E are not the primary point of contact for victims and perpetrators of DVA, especially male victims of female abuse. Most people experiencing or perpetrating DVA are likely to engage with their GP or community services far earlier than with an acute service when the level of violence has reached a point at which hospital attendance is required. Research in Essex has indicated that even high risk victims are more likely to be engaging with primary and community services than A&E and many of the victims would not have come into contact with maternity services as they either had no children, their children were older or they were male. These Quality Standards must apply across all primary and commissioned services to ensure that psychological and emotional harms are given equal status with physical and sexual abuse. A community mental health professional is more likely to identify coercive control and psychological abuse than an A&E nurse especially where the person experiencing the abuse has not recognised it as such. All services commissioned by CCG and GP primary care must be included in these standards if we are to identify abuse against any one where DVA is affecting children and adults at risk living within the household. Within the hospital scenario it is also clear that many people will attend the hospital as an outpatient, for surgery, for specialist admissions without attending A&E, therefore the aim must be for patient records to link across the health sector so that; for example, when a person attends an outpatient appointment there is a marker on their file indicating whether they have previously been screened and the outcome so the professional is able to better assess both the

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			patient and the services required. Therefore it is not just A&E within the acute sector who should undertake DVA screening (whether routine or targeted) to ensure that abuse is always considered by the attending practitioner as a cause or underlying issue for that individual.
41	Research in Practice	Statement 1 and 2	The training for healthcare professionals in making enquiries during a private discussion to identify victims of domestic violence, should include asking about children in the household and whether they are affected by the violence.
49	Sheffield City Council	Statement 1 and 2 Question 4	Response to questions for consultation: • Targeting – while DA/ SA can happen to anyone, women are the primary victims, and gender is the key risk factor and this should be recognised in training and policy. A key risk factor is also the 'intrusive other person' which can be indicative of coercive control. I think these issues should be given weight. However I also think that that professional curiosity and professional judgement are key e.g. re. unexplained or unusual injuries and conditions. Asking the question re. why has this young / old / normally healthy person got this condition or injury? • Privacy – I would suggest this needs to be a conversation where the patient feels able to talk freely e.g. they are not overheard by an 'intrusive other person' and / or other patients / staff not involved in the conversation.
11	The Royal College of Midwives	Statement 1 and 2	Multiple visits to GP's for non specific issues should be included in these 2 statements
22	University of Central Lancashire (UCLAN)	Statement 1 and 2 Question 3	a specialist domestic abuse centre based in hospitals (similar to SARC)
46	Refuge	Statement 1 and 2 Question 3	As outlined above, Refuge believes that all women and children should be routinely asked about domestic violence by all health professionals, regardless of whether an 'indicator' is identified. We know through our extensive contact with these clients that there are often no visible indicators of domestic violence and that women and children can be particularly skilled at concealing evidence of abuse from others, including close family and friends. Apart from the silencing effect that unwarranted self blame, shame and social stigma brings to domestic violence victims, many are threatened with further harm if they disclose. In addition to which, perpetrators are frequently successful in persuading victims that their disclosures will not be believed and is not uncommon for children to fear they will be removed from their homes by social workers if they seek help. There are so many occasions when Refuge staff contact a child's former school (after relocating to Refuge) and discover that teachers were unaware the child had been living with domestic violence. Some Refuge clients tell us that they are less likely to disclose abuse when questions about domestic violence are embedded within a wider health screening process. We therefore believe it is vital that repeated routine enquiry is conducted by health professionals for all women and children regardless of perceived risk status or the presence of predetermined indicators. Asking more than once, and in a sensitive, non-

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			judgmental manner may be more likely to result in disclosure, particularly if the questioner is known to and trusted by the client. A private one to one discussion must take place in a separate room, rather than behind a curtain in a busy ward, which unfortunately is known to happen. Confidentiality must be assured and any circumstances where it must be breached such as safeguarding issues or child protection concerns, explained. The perpetrator, relatives and or associates must not be present. Perpetrators must not be informed about or allowed to discover, through professional carelessness, that the victims has disclosed abuse. One Refuge independent domestic violence advocate (IDVA) described a situation where her client's GP notes were visible during a consultation that her partner also attended; he was able to read details of her disclosure of abuse, which lead to further assaults and meant the client did not disclose again for a considerable period. There are occasions when the use of interpreters will be necessary when questions about domestic abuse are asked. It is essential that interpreters should be unknown to the victim, perpetrator and other associated persons. Family members or friends should not fulfil this function. The list of 'at risk' individuals highlighted in the consultation omits perhaps one of the most vulnerable groups of all - women and children with learning difficulties. It is very important that health services either develop or liaise with professionals skilled in communicating with this client group when asking about domestic violence, so that abuse can be identified and individuals protected from further harm.
47	Institute of Health Visiting	Statement 1 and 2 Question 4	We recognise the importance of both A/E and maternity services for identification of DVA and agree with statements 1 and 2. However, this does exclude urgent care centres/walk in centres - the wording may need amending to include all providers of 'urgent and unscheduled care'. We would also support routine, safe enquiry within mental health services and primary care (GP). Health visitors also meet all new mothers (and many fathers) ante-natally and post-natally, in clinics and in the home. Further, health visitors develop relationships with these parents that last over a period of months and years, so they are well placed to identify indicators and warning signs of DVA. Therefore, health visitors need to offer the opportunity for private, one-to-one discussion as well. The iHV believes there should be a further quality statement, which reads: 'Women presenting to health visiting services with indicators of possible domestic violence or abuse have a private one-to-one discussion.'
4	Royal College of Paediatrics and Child Health	Statement 1 and 2 Question 4	Another statement is needed, children or young people who report domestic violence at their home; such report may be at nursery/school or to health.
4	Royal College of	Statement 1	Reports/suspicion of domestic violence may be disclosed at GP surgery or walk-in centres; these should be included

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	Paediatrics and Child Health	and 2 Question 4	in the places where DV is detected.
32	Standing Together against Domestic Violence	Statement 1 and 2 Question 4	Other related healthcare services that are likely to come across high numbers of survivors of domestic abuse may include primary care, mental health services, drug and alcohol services and sexual and reproductive health services. We would however recommend a 'whole hospital approach' with regards to training and quality standards (please see comments in response to Question 1). At Chelsea and Westminster sexual health accounted for 21% of all identified cases of domestic abuse.
47	Institute of Health Visiting	Statement 1 and 2 Question 5	There is always a danger that use of 'risk groups' or 'indicators' excludes those who suffer from DVA, but do not fit the criteria. This is why we would support 'routine'/'universal' enquiry.
32	Standing Together against Domestic Violence	Statement 1 and 2 Question 5	The key risk factor for domestic violence or abuse is being female. While any woman can experience domestic violence or abuse, not all women are equally at risk. Factors such as age, financial dependence, poverty, disability, homelessness and insecure immigration status can heighten women's vulnerability to abuse or entrap them further. Minority ethnic women may face language barriers or racist discrimination in accessing services, but they may also fear being accused in their communities of bringing shame and dishonour upon their families. They may also be unsure about their immigration status and fear deportation. Carers and women cared for represent another hidden group, at particular risk of experiencing domestic abuse. Disabled women may experience communication or physical barriers to getting help or leaving an abuser, or they may be isolated because of their impairment. Young women are at a higher risk of all forms of abuse yet often this can be minimised, particularly in their teenage years. Similarly older women's experiences of abuse and needs are often overlooked. Lesbian, bisexual and trans-women may experience barriers to service as a result of homophobic or trans-phobic discrimination. For men who are experiencing domestic violence and abuse, we have found that disclosures are most likely to come via sexual health services. Chelsea and Westminster found that 85% of males where domestic abuse was identified were men-who-have-sex-with-men. In that arena, enquiries should be directed at both men and women. Domestic violence or abuse is not always obvious, especially if the abuse is not physical; patients often go to great lengths to conceal it. In addition to the clinical indicators that may alert to the possibility of domestic violence, other signs may include:

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			• Missed appointments and non-compliance with treatment • Denial or minimisation of abuse/injuries • Injuries which don't fit the explanation of the cause • Multiple injuries at different stages of healing • Delay between an injury occurring and seeking medical treatment • Repeated, non-specific symptoms Appearing evasive, socially withdrawn and hesitant
47	Institute of Health Visiting	Statement 1 and 2 Question 6	Health visitors visit parents in their own home, which can potentially offer privacy, but it is very common for partners and other family members to be present. Perpetrators may 'police' their family member to ensure they are not left alone, or resist the use of professional interpreters (which are, in any case, not always as readily available as they should be). It is important to ensure private space is available in clinic settings, therefore, so that health visitors are able to offer alternative opportunities for disclosure. We found many practitioners shared discreet information-giving items such as mirrors, lip salve, pens etc with their clients - this could perhaps be subject to a recommendation for quality improvement
32	Standing Together against Domestic Violence	Statement 1 and 2 Question 6	Consultations should take place on a one-to-one basis unless the patient has specific access requirements. In the case of hearing impaired patients or those whose first language is not English, a professional interpreter will be necessary. An advocate may also be needed for patients with a learning disability. The interpreter must be professional and cannot be a family member, a friend or a carer. Please see Standing Together Guidance on Use of Interpreters (Standing Together, 2008) for further information. All information on the consultation should be documented on the patients' notes.
47	Institute of Health Visiting	Statement 1 and 2 Question 7	The priority here is safety - being safe and feeling safe. Thus private has to mean out of sight and hearing; and with care given to documentation, particularly in any hand-held records. The boundaries of confidentiality need to be discussed, particularly when there are risks to children and/or vulnerable adults.
32	Standing Together against Domestic Violence	Statement 1 and 2 Question 7	Ensuring privacy and confidentiality is essential for protecting victim/survivors experiencing abuse. Disclosure is unlikely if the abusive partner or another person is with the woman. (Patients should not be asked if they would prefer to be seen on their own as they may be unable to answer honestly and this could endanger the client further.) Private should be defined as a separate room where the consultation can take place on a one to one basis without other staff coming into the room, or where it can be overheard by other staff, the woman's partner or patients.
38	Association for	Statement 2	Recognising Domestic violence in maternity services

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	Improvements in the Maternity Services		
38	Association for Improvements in the Maternity Services	Statement 2	Because, as a maternity pressure and support group, we have been running a totally confidential help line for over 50 years, we are entrusted with much information which does not reach health care and other professionals. We would make the following points: 1. It is assumed that professionals will have the ability to "recognise" reports of domestic violence. But we have had a number of worrying cases where assumptions and over-interpretations have led to a damaging cascade of referrals and interventions, which once set in place, were impossible to stop before there was widespread dissemination of erroneous reports to many agencies (eg via MARAC, where supposed victims are not allowed to attend meetings held about them, so have no opportunity to halt the chain of misinformation)
38	Association for Improvements in the Maternity Services	Statement 2	2, We agree that "having a private one-to-one discussion" is useful and important. But no information is given as to how this is to be managed without further risk to the woman whose accompanying relative may be her abuser, especially if she apparently wants his/or her presence. (The abuser may not necessarily be male. In one of our cases, there was long-standing sexual abuse by her mother, who was frequently present.) In the case especially of teenagers, brothers and other family members may also be abusers. 3. The exclusion of anyone accompanying the woman to clinics to enable the one-to-one discussion to happen is recommended at a time when professionals are expected to involve expectant fathers, and new fathers, more in care. How are these divergent policies to be managed? Moreover support (including that from family members is known to have beneficial effects on outcomes. *We suggest that some qualitative research of those conducting clinics should be urgently carried out* 4. We should also point out that one-to-one discussions may sometimes be useful even if there is no domestic abuse. Women will sometimes share concerns with a trusted carer which they may not wish to share with their family supporter (e.g. previous abortions, or causes of trauma like earlier sexual assaults or rape) 5. We would also point out that this is not a static situation, since abuse may start at any stage during, or after pregnancy. So "a" private discussion should be available at every contact. This should not be a one-off: "tick the box, done and dusted". .6. Another problem is that antenatal visits are taken up with prescribed checks, with few opportunities for women to voice their own concerns, especially if they lack education and confidence. This is a common cause of complaint on our help line 7. Many women tell us that multi-agency sharing of data is a powerful disincentive to their reporting violence or coercive control. We have never yet had a case where a report to social services and their involvement has not done more harm than good – firstly by causing great stress which affects the baby, and in one case immediately halted growth. At a time when social workers are ordered to increase adoptions, and newborns are removed at birth in cases of risk, this is an understandable fear. **Where is the evidence of efficacy of such referrals?** The most

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			recent Confidential Enquiry into Maternal Deaths, aware of the concealment of perinatal mental illness which followed such referrals and the large number of maternal suicides, advocated caution. 8. May we emphasise, once again, the potential benefits particularly for higher risk populations, of continuous care from the same midwife, which is more likely to engender trust and to improve understanding. We would welcome a randomised trial. 9. Domestic violence and coercive control are associated with later access of antenatal care, though it is one of a number of such associations. Reduced number of antenatal visits does not, in itself, have a **causal** association with adverse outcomes – it is a fact that those who access care late are likely to have other proven risk factors. However, social workers (untrained in epidemiology) interpret this as "antenatal neglect" and it is seen as yet another indication of the expectant mother being unfit to keep her child. 10. Whilst we are delighted at the statement that professional interpreters should be available, in the real world this is simply not possible immediately for the many languages involved (unless a telephone service is set up) We know of cases where hospital porters have been called on. And in Asian families, community links are such that there is wide distrust even of professionals involved where confidentiality is concerned. SUGGESTION: Notices in all the languages spoken in that catchment area could be put in the women's lavatories telling women how to contact a helper who speaks their own language. This could be helpful since often women only reach out for help at a point where they are ready to do so – which may not be in the context of the busy antenatal clinic. 11. Victims have a right to be referred to services of proven efficacy – especially when they are being referred without their consent, and even when they have refused. We are not satisfied with evidence we have been able to access.e.g. data on MARAC gathered by IDVAs who were collecting and reporting data used to assess the efficacy of their own work. There is a difference between data collection by those involved in the work, and assessment of efficacy, which needs to be independent.
38	Association for Improvements in the Maternity Services	Statement 2	12. In certain individual cases, quality of IDVA training has been highly questionable (one has been dismissed following a client's complaint).
38	Association for Improvements in the Maternity Services	Statement 2	13 We have now received several reports from fathers saying that false allegations of DV have been made by women because this can provide access to legal aid which would not otherwise be available to them. We have in the past seen so many cases where well-to-do male abusers could afford legal aid and women could not, that this is a new development for us.. We are not in a position to judge the accuracy of these allegations, but, like any possibility of false allegations, they cause us concern.
25	Cheshire West and Chester Council	Statement 2	ALL pregnant women should be asked about possible abuse in a kind and reassuring way, not just those where indicators are identified. Pregnancy is a time of high risk of abuse and women may not recognise that what they are experiencing is abuse. They may regard it as normal family life and minimise their experiences. They can be

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			reassured that help to keep safe will be made available if they are experiencing abuse at that, or any future, stage.
48	County Durham and Darlington NHS Foundation Trust	Statement 2	As above. Midwives have the opportunities to be able to facilitate a 1:1 session safely. Fathers are encouraged to participate in ante-natal visits which can sometimes present difficulties - perhaps introduce a mandatory 'mums only' appointment as part of the ante-natal pathway. Midwives should be conducting routine enquiry in the ante-natal period (according to previously published DH guidance) but have not necessarily so far been trained in how to do this and how to respond to disclosure. Midwives should all be trained to ensure that they are able to recognise indicators of possible domestic violence or abuse, conduct risk assessments and have the knowledge and skills to carry out 1:1
44	Cumbria Partnership Foundation NHS Trust	Statement 2	Teenage pregnancies need to be highlighted as a risk area
50	Hampshire Domestic Abuse Steering Group	Statement 2	*Women presenting to maternity services with indicators of possible domestic violence or abuse have a private one-to-one discussion.* • It should be stated that in having a discussion with someone, a direct questions needs to be asked about domestic violence/abuse. Research has shown that many people won't disclose abuse off their own backs, but will (and are relieved to) if asked a very direct question. • Healthcare professionals: need to add some information about the requirement for professionals to make appropriate onward referrals (even to external support agencies) and to SHARE INFORMATION as appropriate with other agencies, particularly DA support agencies and MARACs – rather than feeling bound by patient confidentiality (as is so often the case when non-health agencies try to engage with health services). • Rationale: add something around the fact that research shows that a large proportion of domestic abuse begins during pregnancy or soon after a birth so this group of people are especially important to engage with. • Equality and diversity considerations: Family members of friends MUST not act as interpreters for discussions.
19	London and South Perinatal Consultant Psychiatrists	Statement 2	In maternity settings (if not also A & E), should specific questions about domestic violence be posed, rather than simply allowing women to disclose. Often women do not admit to DV unless directly asked.
53	NHS England	Statement 2	Where emotional, psychological and physical harm are mentioned I would add in sexual harm, as unfortunately often women are raped as part of domestic violence.
6	Northumberland Tyne and	Statement 2	1 *Are there specific 'at risk' groups who should be asked about domestic violence and abuse, for example, people*

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	Wear NHS Foundation Trust		*with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?* disagree, again this should be routine enquiry for all pregnant woman and sought whilst undertaking an element of care that requires the woman to be seen alone This data could be gathered within assessment documentation, flagged and shared with agencies to manage the risk, make decisions re unborn etc To help overcome barriers this should be included in staff training and explained to people of generic question to all *How should 'private' be defined within this setting?* The person should be seen alone (without a family member or associate present) More than one staff present if deemed necessary .
41	Research in Practice	Statement 2	This section should note that children who are or have been looked after, or involved in the child protection system, and teenage mothers are at increased risk of being a victim of domestic or intimate partner violence.
10	Royal College of Obstetricians & Gynaecologists	Statement 2	This statement specifically relates to maternity care and is crucially important. It is current practice in maternity care (at least in NHS Scotland – I am unable to comment on the rest of the UK) for all women presenting to maternity services to have a private one-to-one discussion with a trained healthcare professional to disclose any past or current experiences of domestic violence or abuse. We do not try to identify 'at risk' groups – instead all women are asked about abuse. 'Private' is defined as a discussion held in a clinic room with only the healthcare professional and patient present – (ie partners and other relatives are routinely asked to leave the room whilst the discussion takes place). If the patient is a vulnerable adult then we follow the guidance in the 'Adults with Incapacity' Act.
13	SafeLives	Statement 2	It is very difficult at the ante natal stage to assess the indicators of domestic abuse. Women are not consistently offered a private interview when presenting with their partners. It would be best to offer all women the opportunity to be seen privately, and then assess against indicator best practice.
20	Sanctuary Supported Living- Housing Association	Statement 2	. NICE should consider the one chance rule in relation to women form diverse communities . Women should be seen by professionals form outside their community or ethnic background due to conflict of interests.
12	Somerset Integrated Domestic Abuse Service (SIDAS)	Statement 2	***Quality statement*** Women presenting to maternity services with indicators of possible domestic violence or abuse have a private one-to-one discussion. **Are there specific 'at risk' groups who should be asked about domestic violence and abuse, for example, people with certain indicators, a combination of indicators or a certain number of indicators from the long list in the definitions?**

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			Both Yeovil and Taunton Maternity do routine enquiry with all their pregnant mothers on 'relationships' and abuse. They will highlight those with obvious indicators, but will ask anyone as standard. It's on their paperwork to ask the question. The two Hospital IDVA's are training maternity staff and doing a full audit of their current practices to see what works well. They have found that individuals struggle 'asking the question' even when there are indicators. There will be further training on this for maternity staff. **Given that this population may involve vulnerable patients, in practice would a discussion take place on a one-to-one basis?** The conversations happen in a private room away from other pregnant women, but not always on a one-to-one basis. If the perpetrator is present, they may ask them to leave or they may make an appointment for the mother to come back another time. There is sometimes two or more medical staff in the room with the pregnant mother. **How should 'private' be defined within this setting?** 'Private' should be defined as a space away from others who can hear the conversation and somewhere safely away from the perpetrator and on a one-to-one basis with someone the mother trusts to be non-judgemental and understanding to her needs and those of her unborn child.
32	Standing Together against Domestic Violence	Statement 2	It is recommended that, within maternity services, 'universal' as opposed to 'selective' screening is implemented. All women who present to maternity services should be 'asked the question' about domestic abuse on a private one-to-one basis. Imperial College Health Trust maternity services have a 16-week women's only appointment enshrined in their domestic abuse policy to facilitate 'asking the question' and giving women the opportunity to safely disclose. A growing body of evidence, including the recent follow up to the Bristol Pregnancy and Domestic Violence Programme (Baird et al., 2011, 'A Five Year Follow Up Study of the Bristol Pregnancy Domestic Violence Programme), has highlighted the benefits of 'routine antenatal enquiry' across maternity services. Routine enquiry should be made either when taking a social history at booking or at another point during a woman's antenatal period. All women should be seen alone at least once during the antenatal period to facilitate disclosure of domestic abuse.
11	The Royal College of Midwives	Statement 2	Midwives and other maternity care professionals need to be trained in relation to specific signs of sexual abuse that present in their context (which overlap with some mentioned). All reproductive health professionals should be trained in sensitive care delivery following sexual abuse.
22	University of Central Lancashire (UCLAN)	Statement 2 Question 2	Maternity care is recognised as an important intervention site for domestic abuse, so is very appropriate
22	University of Central Lancashire (UCLAN)	Statement 2 Question 2	as for QS1 measure, but data is likely to be easier to collect in Maternity Services than A&E. Additionally, it would be useful to measure the impact (e.g. self-report well-being, services offered etc) of the private discussion.

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22	University of Central Lancashire (UCLAN)	Statement 2 Question 3	Specialist domestic abuse mid-wife
42	Women's Aid	Statement 2	This Statement could contain the information that domestic abuse often begins or escalates during pregnancy. This risk has been identified as there is currently a routine enquiry programme for midwives to ask all the women they see about domestic abuse.
54	Youth Justice Board	Statement 2	Young girls who are pregnant in custody may be vulnerable and have experienced domestic violence or abuse, which should be considered as part of the initial risk assessment when they arrive in custody.
2	Five (5) Boroughs Partnership NHS Foundation Trust	Statement 2	Not all victims of DV present with symptoms would consideration to include asking all women in a sensitive enquiry
2	5 Boroughs Partnership NHS Foundation Trust	Statement 2	Need to also consider safety of health professional where perpetrator is or likely to be present
2	5 Boroughs Partnership NHS Foundation Trust	Statement 2	What is evidence of local arrangements is it sufficient to be part of policy and patient assessment in patient records
8	Broken Rainbow UK	Statement 3	Assessing Risk – when it comes to the LGBT+ community, consideration needs to be given that the same sex partner may present at the hospital within a different persona, friend etc.
25	Cheshire West and Chester Council	Statement 3 Question 3(b)	Agree an assessment of immediate safety must take place.
48	County Durham and Darlington NHS Foundation Trust	Statement 3	Assessment of safety should include 1. Any injuries requiring immediate attention ? 2. Does patient need a safe place of refuge ? 3. Is partner present / nearby, is police support required ? 4. What are patients wishes and feelings ? 5. Any capacity issues ? 6. Any indicators of immediate risk of harm should patient be disclosed ? 7. Any crimes committed ? 8. Any sexual violence is forensic examination required ? 9. Any child protection issues ? A standardised checklist should be used to identify risk
44	Cumbria Partnership	Statement 3	CADAA risk assessment -**Who is it for? Who can use it?**

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	Foundation NHS Trust		The Dash risk checklist can be used for all intimate partner relationships, including LGBT relationships, as well as for 'honour'-based violence and family violence. It is primarily intended for professionals – both specialist domestic violence workers such as Idvas and other professionals working for mainstream services. There is a specific police version of the risk checklist, which is used by most police forces in England and Wales. Every high-risk victim should have a dedicated domestic violence professional (an Idva) supporting them to live in safety. And it means frontline services must work together to protect them and their family. Idva stands for independent domestic violence advisor. Experts in high risk domestic violence, Idvas provide vital emotional and practical support to victims. They deal with everything from getting an injunction to sorting out money to having the locks changed. Their job is to make sure the victim is safe – and they do whatever it takes. Idvas may work for charities, councils or other organisations like Victim Support or Women's Aid. Many are located out in the community – such as in hospital A&E departments.
1	General Medical Council	Statement 3	It is important that anyone carrying out a safety assessment is trained to do so. Quality standards 1 and 2 say that staff will need training to recognise the possible indicators of domestic violence and abuse, but standard 3 does not mention training, and says only that staff will need to follow a protocol for carrying out safety assessments. It is important that anyone following a safety assessment protocol has an understanding of the risks and safety issues that underpin it. While the *Training and competencies* section in the *Introduction* says that staff will need sufficient and appropriate training and competencies to deliver the actions and interventions described, we recommend adding in a specific requirement for training under standard 3. If GP surgeries are included as one of the services mentioned specifically, it seems likely that safety assessments will fall to doctors directly rather than to other healthcare staff. We say in our guidance that doctors must not act beyond their competence (paragraph 14, *Good medical practice*). If local service providers expect doctors to carry out safety assessments without sufficient knowledge or training, this risks bringing them into conflict with this duty.
50	Hampshire Domestic Abuse Steering Group	Statement 3	*People who disclose domestic violence or abuse have an assessment of their immediate safety.* • Healthcare professionals: need to add some information about the requirement for professionals to make appropriate onward referrals (even to external support agencies) and to SHARE INFORMATION as appropriate with other agencies, particularly DA support agencies and MARACs – rather than feeling bound by patient confidentiality (as is so often the case when non-health agencies try to engage with health

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			services). • DASH risk assessment should be used • Service providers: there needs to be a designated DASH lead/practitioner within services. From experience in training large multi-agency groups to complete DASH and use in their services, the reality is that unless someone is using it very regularly and knows the assessment well (and is confident with it), that it tends not to be done, or is done ineffectively. Having leads of designated people within a service that clients/patients are referred to for their assessment can often result in better outcomes.
37	Leicestershire Partnership NHS Trust	Statement 3	• Nice will need to develop or adopt a recommended tool for assessment and minimum standards for what should follow identification of immediate risk. • Without this it will not be auditable, we will end up comparing 'apples and pears', with a postcode lottery with regard to quality and effectiveness of response. It would not be ethical to assess safety if appropriate response cannot be offered, but … The response will be mulit-agency e.g. social care, housing, police, charitable (third) sector. This creates a problem for a 'health only standard'.
36	London Borough of Enfield	Statement 3	An assessment of immediate safety needs to be asked by trained practitioners who understand and are able to support actions to secure safety. Counting number of assessments carried out will not ensure safety for those disclosing abuse. Suggest this be extended to evaluate effectiveness of interventions.
53	NHS England	Statement 3	Where services are mentioned it would be helpful to include those for victims who are deaf and/or blind, as this is a group of very vulnerable victims for which there are few services available.
6	Northumberland Tyne and Wear NHS Foundation Trust	Statement 3	*What should an 'assessment of immediate safety' involve?* What does the person want support with? Do they feel in immediate danger/fear for their life? Complete a DASH (Risk indicator checklist for MARAC referral if in agreement? Would they like to speak to a Domestic Violence Advocate (IDVA) ? Do they want to report any incidents with the Police? Do they want to be referred to a refuge? What safety plan do they have in place when they return home, eg phone, neighbours, police, support networks etc
30	R.I.S.E.	Statement 3	"Assessment of immediate safety" – some possible indicators: threats to kill were made; serious injuries inflicted; the victim is very fearful; the patient is very vulnerable (very old/young; disabled; recent immigrant). Who is going to carry out the assessment? What training/knowledge of DVA would be expected from the assessor?

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			Will there be a tool (a check list?) helping a medical professional to assess the “immediate safety”? Maybe it would be more realistic to cover two aspects of a patient’s safety by asking: “Are you safe with us now?” and “Do you have a safe place to go?”
46	Refuge	Statement 3	Refuge strongly believes an assessment of immediate safety should always take place 'immediately' and without the perpetrator or other associated person present. Refuge is aware of some services where disclosure of domestic violence triggers an appointment to carry out a risk assessment at a future date. This is inappropriate and could be dangerous. Risk assessment protocols should include more than a check list. Such approaches have the potential to reveal false positives and false negatives and ignore the fact that risk is dynamic and can change moment by moment. Investigating the history of abuse (type and frequency of abuse suffered, severity of injuries/impacts) and exploring any psychologically abusive and controlling behaviours, is essential to assessing risk. This work is best undertaken by a specialist or in consultation with a specialist by, for example, calling the national domestic violence helpline. The need for professionals to share information about risk and act upon concerns about harm across different services and particularly between adult and child services, is crucial and may save lives - a failure to do so can cost lives. Sabina Akhtar was stabbed to death by her husband, Malik Mannan, in September 2008, two months after she told the police he had assaulted her and threatened to kill her. During a period which exceeded a year, Social services received referrals from the police, and two separate health professionals regarding risk to Sabina’s two-year-old son but closed the case each time without making contact with them. An inquest found that significant and serious failings had been made by Greater Manchester Police, Manchester Social Services and the CPS which possibly contributed to Sabina’s death. Rachael Slack and her two-year-old son Auden were killed by Rachael’s ex-partner, Andrew Cairns, in June 2010, after Rachael had reported Cairns to the police for stalking and threatening to kill her. In November 2012, a jury found that Derbyshire Police made a number of failings that contributed to their deaths, including failing to inform Rachael that they had assessed both her and Auden as being at high risk of homicide, and failing to discuss with Rachael steps that could have been taken to address to risks to Auden. We must always remember that babies and young children cannot disclose abuse; we must assume that babies who live with domestic violence, are at risk. We must offer timely supportive services and options to help an abused woman and her child stay safe, recognising that if one is in danger, then the other is likely to also be in danger.

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41	Research in Practice	Statement 3	This should include an assessment of the safety of any children experiencing or witnessing domestic violence, and whether the victim is a vulnerable adult dependent on the perpetrator for meeting care and support needs..
41	Research in Practice	Statement 3	This should include an assessment of the safety of any children experiencing or witnessing domestic violence, and professionals should know how to make a referral to children's social care where a risk to children is identified. Where an adult needing care and support is identified as suffering domestic abuse, healthcare professionals should know how to make a referral to adult safeguarding teams.
13	SafeLives	Statement 3	It should be made clear what 'assessment' means in practice. Staff should use the SafeLives Dash Risk tool if they have been trained to do so, and/or refer to a local specialist and/or liaise with their in house champion. In our consultancy reports we have always recommended having a champion on each team, so that frontline staff have a peer who is more confident/competent in this area. Again, if commissioning doesn't drive this, it won't happen. It should be clear that this has to be a precursor to referral for specialist support - it shouldn't be expected (or implied) that the health professional is responsible for creating or implementing a safety plan, unless they have the specialist expertise and knowledge to do so
20	Sanctuary Supported Living- Housing Association	Statement 3	. Each area should have a health IDVA linking to hospitals and GP practices in areas of high prevalence . A&E staff should have a IDVA on each shift . Provision for vulnerable groups should be considered such as people with complex needs
32	Standing Together against Domestic Violence	Statement 3 Question 8	An assessment of immediate safety needs to include three basic questions: Does the patient need to flee their home today? Are there any current threats to their life that they believe to be real? Will they, or any children or vulnerable adults in the home, be at risk if the patient returns home tonight? If there is a yes to any of these questions an urgent response is required. Professionals should ensure that if an immediate risk is identified appropriate and timely referrals are made to relevant agencies (MARAC, adult and children's safeguarding, police). Leaving can be the most dangerous time for the victim/survivor. It is essential that when health professionals assess the patient's safety, they do not assume that separation equals safety. The assessment should include information on how to contact the police, how to access a refuge or emergency accommodation. The assessment should determine if there are weapons in the home and identify possible escape routes for the victim/survivor and her children. Professionals should always advise victim/survivors to keep text messages and answering machine messages, letters and so on as supporting evidence of the harassment

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22	The ManKind Initiative	Statement 3	The comments in this section are the same as for the above section on Quality Standard 1
11	The Royal College of Midwives	Statement 3	Immediate safety is difficult as most maternity unit these days would find it difficult to admit and women's aid no longer allow instant admission (even if available – when there are lots of cuts to services). Homeless centres are less than ideal especially if the woman has children.
22	University of Central Lancashire (UCLAN)	Statement 3 Question 2	Unless extra resources are made available, it is extremely unlikely that that an assessment of immediate safety will be made. Further once the assessment is made will resources be available to implement the risk/safety plan? The assessment will need to be followed up by a practical plan (e.g. place of safety) co-produced by the person experiencing domestic abuse and the professional. Many professionals would not consider an assessment unless the victim had other vulnerabilities e.g. substance misuse, mental health problems. A (much needed) culture change will be required in adult social care and in health services for domestic abuse to be recognised as a safeguarding issue.
22	University of Central Lancashire (UCLAN)	Statement 3 Question 2	Quality Measure: Yes, it should be possible if appropriate, systems, structures and resources are in place
22	University of Central Lancashire (UCLAN)	Statement 3 Question 3	Culture change within health and social care organisations so that the 'additional' vulnerabilities model to trigger safeguarding is recalibrated so that all people (largely women) are offered an assessment. Training and resources are required as high thresholds to access services are set in times of tight budgetary constraints.
2	5 Boroughs Partnership NHS Foundation Trust	Statement 3	What does an assessment of safety mean, should this include the DASH risk assessment tool (MERIT for Merseyside and Cheshire)
2	5 Boroughs Partnership NHS Foundation Trust	Statement 3	Safety training/ guidance is required to enable staff to effectively separate victims and perpetrators
2	5 Boroughs Partnership NHS Foundation Trust	Statement 3	Consideration that all victims who disclose should have a risk assessment of immediate safety, and if this is agreed there is not a need to identify a proportion as it will be provided for all disclosures
2	5 Boroughs Partnership NHS Foundation Trust	Statement 3	How to capture if people are feeling safe as this could be dependent upon other services actions and might not be an immediate result of risk assessment
26	Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London	Statement 3 and 4	An assessment of immediate safety requires a specialist assessment as detailed above "Specialist support services" should include those detailed above. The "quality" measures listed do not include the outcome of a specialist assessment, but are simply records of frequency of use of services, and record of disclosure. They are therefore quantitative, not qualitative. It is recommended that NICE develops quality measures based on the findings at examination, the referral patterns following assessment, and the outcomes (referral to the police, care measures enforced, etc.)
17	NCSPVA, University of Worcester	Statement 3 to 5	Ensure all services have formal referral pathways in place for domestic violence and abuse. These should support: people who disclose that they have been subjected to it; the perpetrators; and children who have been affected by it.

ID	Stakeholder	Statement number	Comments[3]
			There are huge gaps nationally in terms of who to refer to, particularly with regard to men who perpetrate abuse who may require support to change. In terms of ensuring that staff know, or have access to, information about the services, policies and procedures of all relevant local agencies for people who experience or perpetrate domestic violence and abuse, it might be a good starting point if all health organisations had domestic abuse policies for staff, visitors and patients. Regularly assess what type of service someone needs – immediately and in the longer term. Need and risk is dynamic, so can change on a daily basis. This will therefore be an ongoing process.
54	Youth Justice Board	Statement 3 to 5	**General comments which apply to all three quality statements** For some time, youth justice practitioners have reported high occurrences of family violence, and in many cases adolescent to parent violence and abuse (APVA). However, there is currently an absence of management information which makes it difficult to understand the full scale and extent of this issue. Domestic violence cases and adolescent to parent violence is not specifically flagged on police, health or social care databases. It is also important to note that the numbers reported are likely to represent a small percentage as with all cases of domestic violence and abuse the cases are under-represented. Specifically in cases of APVA parents are particularly reluctant to report violence from their child for fear that their parenting skills may be questioned or they will be disbelieved. APVA is complex, affects all levels of society and the boundaries between 'victim' and 'perpetrator can be unclear. The violence is often contextualised within existing family problems and many 'perpetrators' of violence towards their parents are, or have been victims of secondary victims of domestic violence, abuse or child abuse. Professionals working with cyp and parents should seek to identify risk factors early and work with the family to provide early support to avoid a crisis situation. Professionals managing a perpetrator under the age of 18 in a case of violence or abuse must also ensure the safeguarding needs – as well as any risks posed by this individual – are met. It can be difficult to strike the right balance between safeguarding and public protection. Youth Offending Teams increasingly also link with locally delivered Troubled Families initiative and Community Safety Partnerships, which often also have a responsibility for domestic abuse and violence. As a result of the concerns of the increase in occurrences, the YJB worked with academics and policy makers to develop multi agency guidance to address APVA which was the first of its kind.(Information guide: adolescent to parent violence and abuse).
54	Youth Justice Board	Statement 3 to 5	**Ref to multi agency approach** Local Youth Offending Teams (YOTs) play a key role in cases where children and young people are engaging in

ID	Stakeholder	Statement number	Comments[3]
			domestic violence. YOTs are able to bridge professional boundaries by working across justice agencies – such as the police – and those agencies with a responsibility to protect children – such as Children's Services, multi-agency safeguarding hubs (MASH) and Local Safeguarding Children's Boards (LSCB). This way of working furthermore enables a full risk assessment of the cyp. In addition, YOTs have clear processes to engage with the correct and relevant specialist services that the cyp may need and to ensure that the agencies have adequate safeguarding and safety plans in place.
8	Broken Rainbow UK	Statement 4	There are very few suitable services for the LGBT+ community. Many LBT women will face secondary levels of discrimination when attempting to access generic services. GBT men have very few options.
25	Cheshire West and Chester Council	Statement 4	**Comment1 -**The emphasis on 'specialist support' is welcome. The needs of people experiencing /perpetrating abuse are complex and the risks can be high, with two women a week murdered by their current or ex partner. There needs to be acknowledgement that abused women or men can move from high to medium to low risk or vice versa in a short space of time. Evidence from enquiries into domestic abuse deaths shows that often the victims have not even been in touch with services.
25	Cheshire West and Chester Council	Statement 4	**Comment 2-** There needs to be a clear differentiation between signposting and referral. Both may be appropriate but in different circumstances, taking into account the level of risk and wishes of the patient. Everyone should be given information (if it safe to do so eg by using bar code type phone numbers) on how to seek help even if they do not disclose abuse at their appointment.
25	Cheshire West and Chester Council	Statement 4	**'Comment 3 -** Offering a referral does not necessarily mean that patients will access the help they need. Sometimes they will need support to help them understand the help on offer and what it could mean for them and their family.
25	Cheshire West and Chester Council	Statement 4	**Comment 4 -** Referral to specialist support services -I welcome the acknowledgement that some people affected by abuse are reluctant to use services for a variety of reasons. This can be particularly true of statutory services and referral to a third sector specialist service could be suggested here.
25	Cheshire West and Chester Council	Statement 4 Question 3(b)	Agree should be offered a referral to specialist support services.
48	County Durham and Darlington NHS Foundation Trust	Statement 4	Good quality and readily accessible support services are essential as is multi agency collaboration and communication – local areas should have a multi-agency referral pathway in place which is monitored and updated centrally alongside commissioning of domestic abuse and other support services.
44	Cumbria Partnership Foundation NHS Trust	Statement 4	Domestic Abuse Champions
50	Hampshire Domestic Abuse Steering Group	Statement 4	*People experiencing domestic violence or abuse are offered a referral to specialist support services.* • Referral processes should be as straightforward and non-bureaucratic as possible.

ID	Stakeholder	Statement number	Comments[3]
			• Healthcare professionals: need to add some information about the requirement for professionals to make appropriate onward referrals (even to external support agencies) and to SHARE INFORMATION as appropriate with other agencies, particularly DA support agencies and MARACs – rather than feeling bound by patient confidentiality (as is so often the case when non-health agencies try to engage with health services).
53	NHS England	Statement 4	Under standard 5, services should include mental health and learning disability services as both can provide excellent services/support for their service users who are abusers.
46	Refuge	Statement 4	Refuge is pleased that the consultation includes a focus on referral to specialist support services for those who experience domestic violence or abuse. We would however recommend that services and funding for adults and children affected by domestic violence is integrated. The provision of public funding for such services is vital. Specialist domestic violence services for those with learning difficulties should be added to the list of at risk groups.
41	Research in Practice	Statement 4	Interventions should include services for children, and for victims to understand the impact of domestic violence on their children (Stanley, 2011)
41	Research in Practice	Statement 4	A similar local measure could be added, based on the number of domestic violence where children were present, and the number referred to children's social care where domestic violence is a factor, and the proportion receiving a specialist support service.
41	Research in Practice	Statement 4	This should include how and when to make a referral to children's social care when children are experiencing domestic violence.
41	Research in Practice	Statement 4	The list of bodies that commissioners may wish to work with should include the Local Safeguarding Children Board (LSCB) and Adult Safeguarding Board (ASB).
13	SafeLives	Statement 4	We agree with this statement, though specialist services are very tightly stretched, so it should be recognised that I) not all people need the same level of support; ii) commissioning needs to take into account additional capacity and different profile of women accessing DVA services via health setting (data from our Themis project could be used to help with this). Iii)Also not just DVA specialist services but need much better access to mental health services for mother and child. Iii)referrals won't happen without training for universal staff, champions network etc iv) services should meet quality standards – for example our Leading Lights accreditation mark for community based provision
12	Somerset Integrated Domestic Abuse Service (SIDAS)	Statement 4	***Quality statement*** People experiencing domestic violence or abuse are offered a referral to specialist support services. Both Yeovil and Taunton Hospitals and the GP Surgeries across Mendip and Somerset are being trained how to refer into the SIDAS Service. This is the Somerset Integrated Domestic Abuse Service and is a 24 hour telephone number for victims, perpetrators and those needing advice. The staff on the phone line are able to do the DASH RIC and give advice to professional people and agencies. People experiencing domestic abuse will have contact made within 24 hours if an IDVA is needed and 48 hours for a DAC (low risk support). They will also be able to attend the 'Overcoming Abuse' programme as well as receiving the relevant support.

ID	Stakeholder	Statement number	Comments[3]
			The Hospital and Surgery staff are being asked to identify 'Champions' within their teams who will then be given specialist training on how to refer into the MARAC and how to support their staff. They will act as a single point of contact for domestic abuse within their surgeries and wards. The funding for this training is for one year and if the funding does stop we will know that the training given has been of a high standard to allow the hospital teams to know where and how to refer into SIDAS and the MARAC. SIDAS also has two YPVA's (Young Persons Violence Advisors) who work with 13 – 19 year olds both with people experiencing abuse and the perpetrators. We also have Family Intervention Workers who will work with very young children via Barnardos.
16	Stonewall	Statement 4	Stonewall welcomes the explicit mention of the need for services to support lesbian, gay, bisexual and trans (LGBT) people experiencing domestic violence. LGBT people are at a high risk of experiencing domestic violence and often face barriers to accessing conventional services. Despite this there is limited specialist provision for LGBT people who experience domestic violence. The quality measure should look for evidence of engagement with local LGBT communities and where appropriate and practicable, specialised services commissioned on the basis of that engagement. Commissioners should consider jointly commissioning local services where appropriate and service-providers should make sure that LGBT people who experience domestic violence are signposted to national specialised services such as Broken Rainbow's Domestic Violence Helpline.
16	Stonewall	Statement 4	In Stonewall's consultation with trans people in 2014, many trans women reported experiences and expectations of discrimination when accessing gender-specific mainstream support services, such as domestic violence services.[5] Service-providers should send a clear signal that they welcome and support trans service-users, and commissioners should make sure that appropriate services are in place for trans people experiencing domestic violence. 5 Trans People and Stonewall – Campaigning together for lesbian, gay, bisexual and trans equality (2014)
22	The ManKind Initiative	Statement 4	We greatly welcome the recognition about ensuring there are services to help men. Following on from this however, we would still want our comments for Quality Standard 1 and 3 to be considered as

ID	Stakeholder	Statement number	Comments[3]
			part of the equality and diversity considerations.
22	University of Central Lancashire (UCLAN)	Statement 4 Question 2	Many specialist domestic abuse services have closed down and many have been taken over by generic services hence there is a danger of losing the much needed expertise on domestic abuse issues. In some localities this means that there may be very few specialist services to refer service users to.
22	University of Central Lancashire (UCLAN)	Statement 4 Question 3	Ensure that there are specialist services to refer women to. Many of these, particularly BME women's organisations have shut down due to cuts in funding.
2	5 Boroughs Partnership NHS Foundation Trust	Statement 4	Quality of Local referral pathways for support are dependent upon availability of support services and this should be reflected in the evidence data
2	5 Boroughs Partnership NHS Foundation Trust	Statement 4	Not all victims will agree to a referral and this should be reflected in the numerator, for example numbers of people offered support and numbers agreed to a referral
8	Broken Rainbow UK	Statement 5	To be aware that at the time of writing there are no specialist services for LGBT+ perpetrators in the community. Therefore referral to anger management or counselling services may be seen as the best option.
27	Central Manchester & Manchester University Hospitals NHS Foundation Trust (CMFT)	Statement 5	Currently services are not in place to ensure perpetrators are referred to specific service locally and would need to be developed through multi agency partnerships in combination with victim safety services
25	Cheshire West and Chester Council	Statement 5 Question 3(b)	Agree perpetrators should be offered a referral to specialist support services.
48	County Durham and Darlington NHS Foundation Trust	Statement 5	There is good research evidence that perpetrator programmes used in the correct context with perpetrators who genuinely wish to make changes can be very effective in changing controlling and violent behaviours. This standard to provide programmes for perpetrators should therefore be supported as in some localities such programmes can be difficult to access and or only available via the criminal justice system. It would be useful to include guidance against the use of certain interventions, such as 'anger management' programmes and couples counselling (eg relate), which may be counterproductive or contra-indicated in cases of domestic abuse.
44	Cumbria Partnership Foundation NHS Trust	Statement 5	Ensure interpreters have training/competencies for Domestic Abuse
1	General Medical Council	Statement 5	We welcome the approach to setting levels of achievement, which recognises that safety, choice and professional judgement mean that it may not be appropriate to act in the ways described in the standards in every case. This could be particularly important for quality standard 5, as it is likely that most perpetrators of domestic violence or abuse will be known to be perpetrators because the person they are abusing has disclosed this rather than because they have

ID	Stakeholder	Statement number	Comments[3]
			disclosed it themselves. It will be important for those offering support services to perpetrators to do this sensitively and avoid inadvertently jeopardising the safety of those experiencing violence or abuse. Again, doctors will need to make sure that they follow our guidance on *Confidentiality*. The need for training to ensure doctors act within their competence is also relevant here.
50	Hampshire Domestic Abuse Steering Group	Statement 5	*People perpetrating domestic violence or abuse are offered a referral to specialist support services.* • Referral processes should be as straightforward and non-bureaucratic as possible. • Need to define what counts as a specialist service (e.g. anger management is not appropriate with DA) • Commissioners: should engage in joint commissioning arrangements with other commissioners for a joined up and coordinated approach
37	Leicestershire Partnership NHS Trust	Statement 5	This could prove a challenge for a national standard as the provision of services for perpetrators is so variable (as are the outcomes) but this will highlight the issue.
36	London Borough of Enfield	Statement 5	There is no specialist service for people perpetrating domestic violence or abuse in many localities. Unless govt. prioritises holding perpetrators accountable for their actions, and thus tackling root causes of domestic violence and abuse, this is aspirational.
45	Mid Essex Hospital (NHS) Services Trust	Statement 5	This QS is particularly relevant to GP, community, mental health and substance misuse services. They are most likely to come into contact with abusers, either through disclosure from the victim, or more frequently though disclosure or identification by the attending practitioner. Therefore if these standards only apply to A&E and maternity services there will be little incentive for organisations or commissioners to develop the much needed specialist support required to manage and provide guidance to abusers. Provision of all the services required to prevent abusers continuing their activities is something that, unless it is mandated through such documents as the NICE guidance and standards, will remain lacking and underfunded. I was pleased to see that this was included in the standards as it is a fundamental part of breaing the cycle of violence and abuse.
17	NCSPVA, University of Worcester	Statement 5	In terms of commissioning robust evaluations of the interventions to inform future commissioning. There has been little robust research into What Works with perpetrators of abuse and there is some evidence that one size does not fit all. In the immediate term, there are few providers of perpetrator interventions, with some areas either not having any interventions, or merely offering counselling type services. Not always the best way to assist men who are abusive.
43	North Essex Partnership (NHS) Foundation Trust	Statement 5	This QS is particularly relevant to GP, community, mental health and substance misuse services. They are most likely to come into contact with abusers, either through disclosure from the victim, or more frequently though disclosure or identification by the attending practitioner. Therefore if these standards only apply to A&E and maternity services

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			there will be little incentive for organisations or commissioners to develop the much needed specialist support required to manage and provide guidance to abusers. Provision of all the services required to prevent abusers continuing their activities is something that, unless it is mandated through such documents as the NICE guidance and standards, will remain lacking and underfunded. I was pleased to see that this was included in the standards as it is a fundamental part of breaing the cycle of violence and abuse.
30	R.I.S.E.	Statement 5	Referrals for DVA perpetrators: How perpetrators are going to be identified? Information disclosed by a victim can't be used – if the perpetrator will realise that DVA has been disclosed by the victim, the risk to the victim will increase. How the medical professionals/organisations are going to protect themselves from violence and abuse cause by an alleged perpetrator? Are the professionals going to rely on the perpetrators admitting that they are violent/abusive to someone? There is very limited support available for the perpetrators of DVA in our area. Is this going to raise unrealistic expectations for those perpetrating the abuse and/or unrealistic demands for the professionals?
46	Refuge	Statement 5	There is little if any evidence to date that perpetrator groups eradicate abusive behaviour. We are aware that the debate about 'what works' in terms of perpetrator programmes has shifted to include 'steps towards change' rather than the cessation of all abuse. Refuge recently surveyed a number of abused women about perpetrator groups and asked if 'making steps towards changing abusive behaviour' would be an acceptable degree of change for them to see in their ex-partner after attendance at such a group. The vast majority said it would not and they would want to see an end to all forms of abuse, such as control, humiliation, financial abuse, belittling etc instead. There is clearly a great deal more research required before such programmes are rolled out across the country.
10	Royal College of Obstetricians & Gynaecologists	Statement 5	This is going to be difficult as many areas will not have services (this is highlighted in the QS). Could NICE suggest some examples – or give a model for this statement as this is going to be very difficult to implement
13	SafeLives	Statement 5	We have reservations about this. There will be a judgement required as to what action needs to be taken when someone discloses they are a perpetrator of abuse. In some instances there will be statutory requirements to call the police, mental health professionals or child safeguarding specialists. It shouldn't be assumed that a referral for support is immediately the right course of action. Our second reservation is the availability of services for perpetrators. These are extremely limited and won't be available in every local area or suitable for every perpetrator.

ID	Stakeholder	Statement number	Comments[3]
			That makes this a difficult standard for staff to live up to, and if not agreed in advance with those small number of specialist services, might lead to no onward action or inappropriate action, increasing risk to the perpetrator's victim(s). This reinforces yet again why integrated commissioning of services is so crucial.
12	Somerset Integrated Domestic Abuse Service (SIDAS)	Statement 5	***Quality Statement*** People perpetrating domestic violence or abuse are offered a referral to specialist support services. Both Yeovil and Taunton Hospitals and the GP Surgeries across Mendip and Somerset are being trained how to refer into the SIDAS Service. This is the Somerset Integrated Domestic Abuse Service and is a 24 hour telephone number for victims, perpetrators and those needing advice. The staff on the phone line are able to do the DASH RIC and advice on MARAC. Victims will have contact made within 24 hours if an IDVA is needed and 48 hours for a DAC (lower risk support). The Hospital and Surgery staff are being asked to identify 'Champions' within their teams who will then be given specialist training on how to refer into the MARAC and how to support their staff. They will act as a single point of contact for domestic abuse within their surgeries and wards. Perpetrators are also worked with by the staff at SIDAS and are offered a place on the 'Lifeline' programme. SIDAS also has two YPVA's (Young Persons Violence Advisors) who work with 13 – 19 year olds both with people experiencing abuse and the perpetrators. We also have Family Intervention Workers who will work with very young children via Barnardos.
22	The ManKind Initiative	Statement 5	As far as the charity is aware there are no formal specialist services for female perpetrators of domestic abuse, sexual violence, FGM or honour-based crimes. The charity's main focus is on domestic abuse. In terms of equality and diversity considerations therefore, it should be recognised that there is no such programmes and this minority group of perpetrators should be recognised under this section.
2	5 Boroughs Partnership NHS Foundation Trust	Statement 5	Should reflect where services are limited for example ' evidence of local referral pathway, **where services are available'**
2	5 Boroughs Partnership NHS Foundation Trust	Statement 5	not all perpetrators will agree to have a referral and this should be reflected in the numerators and outcome
48	County Durham and Darlington NHS Foundation Trust	Statement 9	A strategic multi-agency partnership is essential to have a steer and co-ordinate this area of work such as sevice provision, multi-agency training provision and referral pathways. The partnership would also measure outcomes and evaluate efficacy of service delivery.

Registered stakeholders who submitted comments at consultation

5 Boroughs Partnership NHS Foundation Trust

Against Violence and Abuse (AVA)

Association for Improvements in the Maternity Services

Association of Directors of Adult Services (ADASS)

British Association of Sexual Health and HIV (BASHH) Sexual Violence Group

British Medical Association

Broken Rainbow UK

Central Manchester and Manchester University Hospitals NHS Foundation Trust (CMFT)

Cheshire West and Cheshire Council

City Health Care Partnership CIC

County Durham and Darlington NHS Foundation Trust

Cumbria Partnership Foundation NHS Trust

Durham County Council

Faculty of Forensic and Legal Medicine at the Royal College of Physicians of London

General Medical Council

Hampshire Domestic Abuse Steering Group

Institute of Health Visiting

Leeway Domestic Violence and Abuse Services

Leicestershire Partnership NHS Trust

London and South Perinatal Consultant Psychiatrists
London Borough of Enfield
Mid Essex Hospital NHS Services Trust
NCSPVA University of Worcester
NHS England
NHS Solihull CCG
NIHR CLAHRC North Thames
North Essex Partnership NHS Foundation Trust
PARITY Equal Rights for Men and Women
Public Health England
R.I.S.E.
Refuge
Research in Practice
Rotherham Doncaster & South Humber NHS Trust
Royal College of Emergency Medicine
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
SafeLives (formerly Caada)
Sanctuary Supported Living – Housing Association

Sheffield City Council
Sheffield Children's Hospital
Somerset Integrated Domestic Abuse Service (SIDAS)
South West Yorkshire Partnership NHS Foundation Trust
Standing Together against Domestic Violence
Stonewall
The ManKind Initiative
The Royal College of General Practitioners (RCGP)
The Royal College of Midwives
The Royal College of Psychiatrists
University of Central Lancashire (UCLAN)
Women's Aid
Youth Justice Board

Appendix 2: Quality standard internal checks table

Comment number	Page number Or **'general'** for comments on the whole document	Statement number Or **'general'** for comments on the whole document	Comments
NICE quality standard team			
1		General	Support for the quality standard in promoting uptake of the NICE domestic violence guideline and particularly the focus in the health sector which was considered to help dispel beliefs that DVA is a criminal justice issue.
2		General	Suggestion that the QS could act as a lever for CQC in promoting health interests and taking this work forward resulting in more effective cross boundary working particularly in relation to the role of A & E and GPs.
3		Statement 1	Support for including A & E settings – it was suggested that this would help with recognition and ensure referral pathways are place.
4		Question 4	Suggestion to include GP settings.