The Domestic Abuse Commissioner's response to NHS England's 10 Year Health Plan Consultation

Change NHS

Question 1

What does your organisation want to see included in the 10 Year Health Plan and why?

Role of the Domestic Abuse Commissioner

The Domestic Abuse Act establishes in law the Office of the Domestic Abuse Commissioner for the purpose of providing public leadership on domestic abuse issues and to play a key role in overseeing and monitoring the provision of domestic abuse services in England and Wales. The role of the Commissioner is to encourage good practice in preventing domestic abuse and improve the protection and provision of support to people affected by domestic abuse, by holding agencies and Government to account.

The Domestic Abuse Commissioner for England and Wales welcomes the opportunity to submit views on the NHS 10-year Health Plan for England and would be happy to discuss the contents of this response further, if requested to do so.

Intersectionality

Domestic abuse does not exist in a single form. It is unique to each person's situation and history. Different forms of domestic abuse, including controlling and coercive behaviours, coexist in most contexts and it is important to understand how power and control manifest in these situations. 'Race'/ethnicity, age, gender, religion, sexuality, socio economic status, immigration status, disability status and other ways in which victims/survivors identify plays a crucial role in their experience of abuse, its impact and their ability to access pathways of support and recovery. Specialist pathways of support as well as any attempt to understand victim/survivor needs should be responsive to the multiple contexts of oppression and vulnerabilities that they experience.

Health: a domestic abuse Issue

Domestic abuse is estimated to cost the health service over £2bn in one year,[1] affecting at least 2.3 million adults per year. Healthcare settings provide one of

[1] Whole Health London project - SafeLives

the earliest and most trusted places for victims and survivors to access support. It is therefore critical that the NHS embeds a systemic approach to responding to domestic abuse across all healthcare settings.

The Commissioner's 2022 mapping report, A Patchwork of Provision[2], found that not only are health settings primary places for disclosure of domestic abuse, they are also the home to crucial services for adult and child victims and survivors.

Health professionals hold a unique position of trust that can facilitate disclosures. They were most often the first professionals that victims and survivors disclosed abuse to, with 44% of victims and survivors having disclosed to a healthcare worker first. Healthcare settings can sometimes be the only places survivors can go alone, and are trusted by survivors more than other settings. Concerningly, despite this, referrals and signposting to specialist local domestic abuse services from practitioners are alarmingly low – only 19% of survivors found out about domestic abuse support available to them from healthcare workers.[3]

Domestic Homicide Reviews (now called Domestic Abuse Related Deaths Reviews) also consistently find that one of the only services in touch with both the victim and the perpetrator is a local health service. In 2023, the Commissioner published research conducted by the HALT research team at Manchester Metropolitan University[4]. In the study, which consisted of 59 DHR's published between 2017-2019, analysis found that routine inquiry in a range of health settings is absent, with lost opportunities for intervention. Improving the response to domestic abuse must be tackled by improved risk assessments across all healthcare settings which are crucial to ensuring safety for domestic abuse victims at their first disclosure.

In the 2022 Women's Health Strategy[5], evidence submitted highlighted that the health impacts of violence and abuse, including domestic abuse, are wide ranging and extensive, and can have long-term impacts on women and girl's physical and mental health. Findings included the need for healthcare professionals to be able to understand and spot the signs of domestic abuse, to understand the specific needs of victims, including having access to trauma-informed services and how employers can do more to support victims of abuse – both in and outside of the workplace.

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[2] DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf (domesticabusecommissioner.uk)
[3] DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf (domesticabusecommissioner.uk)
[4] Briefing-Paper-Health-Services-Domestic-Homicide-Oversight-Mechanism-2023.pdf (domesticabusecommissioner.uk)
[5] Women's Health Strategy for England - GOV.UK (www.gov.uk)

Fundamentally, domestic abuse is a public health issue that can have serious impact on a person's physical, emotional, mental and sexual health. Domestic abuse is a complex and multi-faceted form of crime. It can be physical, verbal, sexual, emotional, psychological, economic. It can be combination of these and include many other forms of harmful behaviours. Domestic abuse and VAWG ultimately has a harmful and long-term impact on a victim-survivors mental and physical health and without early intervention from healthcare professionals, this will continue to increase demands for all healthcare settings across the NHS and put more victim-survivors at risk of further abuse.

Recommendations: A Coordinated Community Response

The NHS is an important partner within the Coordinated Community Response (CCR) to domestic abuse. As pioneered by Standing Together Against Domestic Abuse;[6] the CCR enables a whole system response to a whole person and their immediate family, shifting the onus off victims and survivors to seek support, and putting it on the systems which ought to be supporting them. A successful CCR requires health systems and interventions to collaborate across their local area. Yet this cannot be achieved without ensuring all professionals have clear understanding of the nuances of domestic abuse and the pathways available to support victim-survivor to remain safe.

The new Duty to Collaborate, introduced by the Victim and Prisoners Act 2024, provides a critical opportunity for the NHS to strengthen its role in the local CCR, particularly via the completion of joint strategic needs assessment by Integrated Care Boards, Local Authorities and Police and Crime Commissioners.

The Domestic Abuse Commissioner therefore makes the following overarching recommendations:

- The NHS embeds awareness and understanding of domestic abuse through implementing mandatory and continuous domestic abuse training for all NHS staff, from frontline professionals to senior management. This must include (but not limited to)
    - non-fatal strangulation and suffocation[7], to ensure that victims-survivors of strangulation are treated promptly through a medical and forensic lens.
    - how domestic abuse affects the mental health of survivors.

[6] What is a CCR? — Standing Together
[7] Survey: strangulation in consensual sex is highest amongst age group 16-34 - Institute for Addressing Strangulation (ifas.org.uk)

    - understanding that children and young people are victims of domestic abuse in their own right, and how they may be affected, including developmental delays as well as physical and mental ill health.
- Through Integrated Care Boards, auditing the training offer across all Trusts, and taking action where training falls short.
- All healthcare settings should create policies and produce clear referral pathways to domestic abuse services, including behaviour change programmes, locally.
- Initiatives and policies that recognise and support victims and survivors of domestic abuse within the NHS, as well as taking a safe and robust approach to employees found to be perpetrating abuse.
- Provide victims and survivors with lived experience of domestic abuse the opportunity to feed into the development of all training modules, policies and referral pathways to so they can share their experience to influence change. Learnings on this approach can be taken from the NHS peer support worker model.[8]

Question 2

What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

The Domestic Abuse Commissioner wishes here to highlight the potential that initiatives such as whole health approaches to domestic abuse, and collaboration between specialist domestic abuse organisations and GPs and maternity care in particular, have to play in improving the health response to domestic abuse.

She also wishes to set out her concerns about the current specific barriers facing children and young people experiencing domestic abuse, migrant survivors of domestic abuse, and survivors with mental health needs.

Whole Health Approach

In the face of the many health challenges facing domestic abuse survivors, the Whole Health Approach[9] has been developed by Standing Together Against Domestic Abuse. This project saw the 'Whole Health' model rolled out in 8 sites across the UK, in partnership with other specialist domestic abuse organisations. As set out in the Pathfinder Toolkit[10], it aims to transform the healthcare response

[8] Peer support worker | Health Careers
[9] Crossing Pathways — Standing Together
[10] Health - Pathfinder — Standing Together

to domestic abuse by ensuring a coordinated and consistent approach across the local health system including acute, mental health and primary care services.

Evaluation of the Pathfinder project found that health interventions were able to reach a wider range of victims and survivors and provide support, as well as identifying abuse at an earlier stage. Pathfinder's evaluation showed that 91% of clients felt safer, 95% had improved wellbeing and 85% reported a higher quality of life. In terms of the abuse, 75% reported that the physical abuse had stopped, 50% that the physical abuse had stopped, and 38% that the jealous and controlling behaviour had stopped. Despite the clear success of the project, its funding ended in March 2020.

The Crossing Pathways project,[11] which includes victim support and professional training, builds upon the Pathfinder Toolkit[12]. Full evaluation is due early 2025, with emerging insights highlighting the crucial need to invest in a 'whole health' approach and sustainably fund health and domestic abuse interventions.

GPs

GPs play an important role within the coordinated community response to domestic abuse and are often patients' first call for healthcare advice prior to entering hospital. IRISi (Identification and Referral to Improve Safety)[13] is an organisation which focuses on improving the healthcare response to domestic abuse and VAWG. IRISi provides specialist domestic abuse training, support, and referral programmes for GPs, which involve collaboration between primary care and specialist domestic abuse organisations.

Between April 2022 and March 2023, IRISi and ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments)[14] operated in 40 UK areas and received 6,333 referrals. Since first launching in 2010, the total referrals amount to 36,352.

The work evidence and evaluated by IRISi highlights that - when compared with the NICE recommendation for flu vaccination - IRISi is shown to be 4.8 times more cost-effective than the flu jab. This includes analysis of both the Return On Investment (£16.79:£1) and Social Return On Investment (£10.71:£1). [15]

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[11] Crossing Pathways — Standing Together
[12] Pathfinder Toolkit — Standing Together
[13] About the IRIS programme - IRISi
[14] About the IRIS programme - IRISi
[15] Is it worth investing in the IRIS Programme? New research concludes "the value of IRIS extends far beyond increasing referrals to Domestic Abuse services or improving service users' lives" - IRISi

Maternity care

The importance of routine inquiry in facilitating disclosures of domestic abuse is vital. However, analysis of Domestic Abuse Related Death Reviews consistently note the value of professional curiosity when it comes to domestic abuse in order to support disclosures and refer to specialist services.[16]

Pregnancy is one of the only times in a person's life where it is guaranteed that they will have consistent contact with health services, including multiple appointments with midwives over the course of the pregnancy, a follow-up with their GP after birth, and regular contact with health visitors in the perinatal period. Maternity care therefore provides a crucial setting for robust routine inquiry and professional curiosity.

Domestic abuse during pregnancy report prevalence rates between 3.4% and 5.8%. The actual incidence is likely to be higher because domestic abuse is highly prone to underreporting.[17] Midwives often serve as one of the first points of contact for pregnant women. On a daily basis, Midwives across the country offer a unique place to provide a non-judgmental space that helps establish trust, creating a safe space for women to disclose abuse.

Community sexual health settings

The intersection between sexual health and domestic abuse can range from sexual coercion to reproductive control. Community sexual health care settings play a vital role in identifying domestic abuse given their frequent interactions with individuals who may not access other services. Sexual health clinics often provide confidential and non-judgmental environments which are crucial for victim-survivors build trust to disclose abuse.

Children as victims of domestic abuse

In 2021, The Domestic Abuse Act introduced into law that children are victims in their own right. This includes children who have seen, heard, or experienced the effects of domestic abuse, and are related to either the victim of the abusive behaviour, or the perpetrator.

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[16] Briefing-Paper-Health-Services-Domestic-Homicide-Oversight-Mechanism-2023.pdf (domesticabusecommissioner.uk)

[17] Domestic abuse (nct.org.uk)

The Commissioner's mapping research found just 29 per cent of victims and survivors reported that they were able to access the specialist support they wanted for their children.[18] In 2025, The Domestic Abuse Commissioner will be publishing a policy report which will include mapping the provision of support services specifically designed for children, to identify gaps and highlight good practice and would urge DHSC and NHSE to read the documents in full when published.

Migrant victims and survivors

Migrant victims and survivors of domestic abuse face some of the most significant barriers to accessing support simply because of their immigration status. Research from London School of Economics and Oxford Migration Observatory estimates that there are approximately 32,000 victims and survivors in England and Wales who would choose to come forward for support, but are prevented from doing so as a result of their No Recourse to Public Funds (NFPF) status.[19]

It is the Commissioner's view that everyone should be equally protected from domestic abuse, and able to access the support they need, irrespective of their immigration status. The largest cost related to supporting victims with NRPF is borne by the NHS in treating the injuries and consequent medical problems of victims.[20] The Home Office (2019) estimated this cost to be £1,200 in 2017 prices; uprated to 2020/21 values it is £1,347.31. This is recognised within the National NHS Objectives 2023/24, which highlighted prioritising health inequalities for marginalised populations, including 'vulnerable migrants'.[21]

In 2024, specialist 'by and for' organisations research highlighted the benefits for migrant victim-survivors of VAWG with NRPF being able to access specialist, intersectional support designed and delivered by and for Black, minoritised and migrant women 'by and for' services'. Findings highlighted if NHSE invested in 'by and for' support, this would create a net-saving £11,444, per victim-survivor over a three-year period. The sectors report is shines a light on migrant women, their needs, and the moral, financial and system cost of denying safety by refusing recognising that the NHS bears the single greatest cost-burden of VAWG against victim-survivors with NRPF.[22]

[18] DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf (domesticabusecommissioner.uk)
[19] Safety-before-status-The-Solutions.pdf (domesticabusecommissioner.uk)
[20] Safety-before-status-The-Solutions.pdf (domesticabusecommissioner.uk)
[21] PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)
[22] investing-in-safety-report-final.pdf (southallblacksisters.org.uk)

Mental Heath

The Commissioner's mapping report indicates the way in which survivors with mental health needs can be caught in a trap unable to access any support whatsoever: specialist domestic abuse services are not funded or equipped to meet specific mental health needs, while simultaneously these needs are determined 'too specialist' for mainstream mental health services.[23] This disproportionately affects black and mixed-race women - the previous Government's 2018 Race Disparity Audit found 29% of Black and mixed-race women had a mental health problem compared to 21% of white British women and 16% of women of other or white ethnicity.[24]

Investment in mental health and recovery from domestic abuse is desperately needed. Timely and appropriate mental health interventions should be funded to address the rise in prevalence and complexity of women's mental health needs. These services should be trauma-, gender-, and culturally- informed, as set out in the Women's Mental Health Taskforce's recommendations.[25] However, statistics from Standing Together Against Domestic Abuse highlighted significant gaps in mental health interventions, with only 13.6% of areas reported to have a Mental Health IDVA in place.[26]

Recommendations

- Existing research and evaluation by IRISi and ADViSe should be used to inform consideration of funding further interventions with GPs.
- Funding and wider roll-out of a whole health approach to preventing and tackling domestic abuse should be resumed.
- The response to domestic abuse in maternity services should be priorities within broader health-related policies.
- A pilot of IDVAs co-located in maternity services should be introduced.
- Incorporate routine enquiry questions about domestic abuse, safety and relationships within community sexual health settings, including clear referral pathways to specialist support.
- Investment and commitment should ensure that all healthcare professionals in contact with babies, children and young people receive both mandatory and regular training on domestic abuse, to enable professionals to respond to them appropriately as victims in their own right.

[23] DAC_Mapping-Abuse-Suvivors_Long-Policy-Report_Nov2022_FA.pdf (domesticabusecommissioner.uk)
[24] Microsoft Word - Revised RDA report March 2018.docx (publishing.service.gov.uk)
[25] The Women's Mental Health Taskforce report (publishing.service.gov.uk)
[26] Map — Standing Together

- Learnings should be taken from the specialist sector's report Investing in Safety[27] report, which highlights that local NHS services are being the single greatest cost-beneficiary of the prevention and support provided by 'by and for' services to victims and survivors with NRPF.
- Mental Health Trusts should be supported to respond effectively to the rise in demand and complexity of victims and survivors of domestic abuse needing support, by introducing IDVA's co-located within departments – including Child and Adolescent Mental Health Services (CAMHS).

Question 3

What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Improving how we use technology across health and care could have a big impact on our health and care services in the future.

As highlighted in the previous Government's Tackling Domestic Abuse Plan, an issue facing healthcare settings in their response to domestic abuse is a lack of comprehensive, comparable, and disaggregated data on victims, survivors and perpetrators, including information on protected characteristics.[28] The Commissioner is pleased to see NHS England's Domestic Abuse and Sexual Violence team address the need to improve data collection through their data improvement project. This work must remain a priority for NHS England. Currently, there are gaps in data collected by the NHS which hinders professionals recognising the patterns of domestic abuse throughout the victim's journey throughout healthcare settings. Improved data on the characteristics of victims and survivors will help to ensure that the impact of domestic abuse on specific groups can be collated and responded to appropriately.

Analysis of DHR recommendations for healthcare settings has highlighted that co-ordinated care is hampered by non-aligned IT systems or not using IT capacity - to 'flag' DVA perpetrators, victims, and frequent or non-attenders. Additionally, findings called for the NHS to produce clear and concise national guidance on when healthcare professionals can share information with other agencies, particularly where a patient does not give consent but is assessed as at risk. [29]

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[27] investing-in-safety-report-final.pdf (southallblacksisters.org.uk)
[28] Tackling Domestic Abuse Plan - Command paper 639 (accessible) - GOV.UK (www.gov.uk)
[29] Briefing-Paper-Health-Services-Domestic-Homicide-Oversight-Mechanism-2023.pdf (domesticabusecommissioner.uk)

Recommendation

Continued investment should be made to improve and implement a robust healthcare data infrastructure, so that information on victims and perpetrators can be identified and holistically responded to.

Question 4

What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Domestic abuse, especially in forms such as coercive control, can often remain hidden. When victims and survivors access healthcare appointments, they may present seeking help for associated conditions, such as mental health problems, or physical injuries which may not at the surface appear to be connected to domestic abuse.

To ensure all forms of domestic abuse are better identified and responded to, there is significant value in having domestic abuse specialists, such as Independent Domestic Violence Advisors (IDVAs) co-located across all healthcare settings. IDVAs provide critical support for victims of domestic abuse. Integration of an IDVA within a healthcare department allows staff to build good working relationships with local specialist services. This helps to create an environment disclosures and ensure effective referral routes for holistic support[30]. This has the potential to reduce short-medium term future costs to the healthcare system, such as repeat visits for untreated or escalating abuse-related issues, by reducing the risks faced and improving the safety of the victim. Furthermore, timely intervention by IDVAs can a bridge the gap in the prevention of long-term health issues by helping to prevent potential longer-term physical and mental health conditions caused by domestic abuse.

However, current IDVA provision across healthcare settings England is piecemeal. Much of this provision is not funded within core commissioning contracts from Integrated Care Boards (ICB's) or by NHS England. These roles often are too often implemented through pilots on grant-based funding.

Case Study

Yorkshire Ambulance Service provides emergency response and NHS 111 services pan-Yorkshire and North-East Lincolnshire visiting 800,00 clinical incidents, 1.2

[30] A hospital-based independent domestic violence advisor service: demand and response during the Covid-19 pandemic | BMC Health Services Research | Full Text (biomedcentral.com)

million 999 calls & 1.5 million 111 calls each year. Yorkshire Ambulance Service is the first service in England to appoint an accredited IDVA within the Trust, which is currently being piloted until March 2025.

Feedback from the pilot has highlighted the IDVA has provided invaluable support to professionals in how to manage disclosures, both from the public and from NHS staff who are themselves experiencing domestic abuse. IDVAs have provided training to staff to raise awareness signposting to support, including referrals to Multi Agency Risk Assessment Conferences (MARAC) and are working with the strategic leaders within the service to develop a domestic abuse policy.

Recommendations

- Integrated Care Boards should map the currently specialist domestic abuse provision within healthcare settings across their local area to inform the new Joint Strategic Needs Assessment (stemming from the Victims and Prisoners Act 2024.)
- Investment and commitment should be made to embed specialist domestic abuse support across all healthcare settings.